- Weather conditions, including whether the child was left in a location with adequate protection from the natural elements, such as adequate heat, light or shelter;
- Condition or location of the place where the child was left without care and support, including supervision;
- The location and accessibility of the parent or guardian to the child;
- The physical distance the child was from the parent or guardian at the time the child was without care and support, including supervision;
- Whether the child was given a phone number of a person or location to call in the event of an emergency and whether the child was capable of making an emergency call;
- Whether the child's movement was restricted;
- The child's access to or ability to access provisions necessary for his or her physical well-being, such as food, water, necessary medication or medical treatments;
- The age and physical and mental capabilities of the caregiver;
- The number and ages of the children left at the location;
- Other factors that may endanger the health and safety of the child;
- Other factors that demonstrate that the parent or caregiver took other precautionary measures to prevent or mitigate the risk of any harm to the child.

75

Abandonment/Desertion

Abandonment

Abandonment is parental/legal guardian conduct that demonstrates the purpose of relinquishing all parental/legal rights and claims to the child. Abandonment is also defined as any parental or caregiver conduct that evinces a settled purpose to forego all parental/legal claims to the child.

Desertion

Desertion is any conduct on the part of a parent or legal guardian that indicates that the parent or legal guardian has no intention, now or in the future, to maintain any degree of interest, concern or responsibility for the child. Desertion includes leaving a child with no apparent intention to return unless the child has been left in the care of a relative.

Examples

- Leave a baby on a doorstep;
- Leave a baby in a garbage can;
- Leave a child with no apparent intention to return;
- Leave a child with an appropriate caregiver without a proper plan of care.

76

Inadequate Food

Inadequate food means that there is a lack of food adequate to sustain normal functioning. It is not as severe as malnutrition or failure to thrive, both of which require a medical diagnosis.

Examples

- The child frequently and repeatedly misses meals or is frequently and repeatedly fed insufficient amounts of food;
- The child frequently and repeatedly asks neighbors for food and other information substantiates that the child is not being fed;
- The child is frequently and repeatedly fed unwholesome foods when his or her age, developmental stage and physical condition are considered.

Factors To Be Considered

Child Factors

- The child's age;
- The child's developmental stage;
- The child's physical condition, particularly related to the need for a special diet;
- The child's mental abilities, particularly related to his or her ability to obtain and prepare his or her own food.

Incident Factors

- The frequency of the occurrence;
- The duration of the occurrence;
- The pattern or chronicity of occurrence;
- Previous history of occurrences;
- The availability of adequate food.

Investigative decisions must never be influenced in any way by the

family's economic status. The fact that a family is poor should play no part in the decision to indicate or unfound the report. In order to indicate a report for this allegation, the investigator must determine that the allegation is due to some reason other than financial circumstances alone.

77

Inadequate Shelter

Inadequate shelter means there is a lack of shelter that is safe and that protects the children from the elements.

Examples

- No housing or shelter;
- Condemned housing;
- Housing with exposed, frayed wiring;
- Housing with structural defects that endanger the health or safety of a child;
- Housing with indoor temperatures consistently below 50°F;
- Housing with broken windows in sub-zero weather;
- Housing that is an obvious fire hazard to a reasonable person;
- Housing with an unsafe heat source that poses a fire hazard or threat of asphyxiation.

Factors To Be Considered

Child Factors

- The child's age;
- The child's developmental stage;
- The child's physical condition, particularly when it may be aggravated by the inadequate shelter;
- The child's mental abilities, particularly related to the child's ability to comprehend the dangers posed by the inadequate shelter.

Shelter Factors

- Seriousness of the problem;
- Frequency of the problem;
- Duration of the problem;

- Pattern or chronicity of the problem;
- Previous history of shelter-related problems.

Investigative decisions must never be influenced in any way by the family's economic status. The fact that a family is poor should play no part in the decision to indicate or unfound the report. In order to indicate a report for this allegation, the investigator must determine that the allegation is due to some reason other than financial circumstances alone.

78

Inadequate Clothing

Inadequate clothing means a lack of appropriate clothing to protect the child from the elements.

Factors To Be Considered

Child Factors

- The child's age;
- The child's developmental stage;
- The child's physical condition, particularly related to conditions that may be aggravated by exposure to the elements;
- The child's mental abilities, particularly related to his or her ability to obtain appropriate clothing.

Incident Factors

- Frequency of the incident;
- Duration of the incident;
- Chronicity or pattern of similar incidents;
- Weather conditions such as extreme heat or extreme cold.

Investigative decisions must never be influenced in any way by the family's economic status. The fact that a family is poor should play no part in the decision to indicate or unfound the report. In order to indicate a report for this allegation, the investigator must determine that the allegation is due to some reason other than financial circumstances alone.

79

Medical Neglect

Medical or Dental Treatment

Lack of medical or dental treatment for a health problem or condition that, if untreated or not treated as prescribed, could become severe enough to constitute serious or long-term harm to the child; lack of

follow-through on a reasonable prescribed medical or dental treatment plan for a condition that could become serious enough to constitute serious or long-term harm to the child if the treatment or treatment plan goes unimplemented.

Treatment is the administration of a remedy to cure a health condition.

Management is the practice of providing care of a chronic medical condition.

Lack of medical or dental management for a health problem or condition that, if unmanaged or not managed as prescribed, could become severe enough to constitute serious or long-term harm to the child.

Lack of proper or necessary health care recognized under State law as necessary for the child's well-being.

Proper and necessary preventive health care to include preventive health care, such as HIV and newborn screening tests that place children at serious risk of illness due to lack of early detection and treatment.

Health care professionals include physicians, nurse practitioners, nurses, dentists, physical therapists, infant development specialists and nutritionists.

Factors To Be Considered

- The child's age, particularly as it relates to the child's ability to obtain and implement a treatment/management plan;
- The child's developmental stage;
- The child's physical condition;
- The seriousness of the current health problem;
- The probable outcome if the current health problem is not treated and the seriousness of that outcome;
- The generally accepted health benefits of the prescribed treatment;
- The generally recognized side effects/harms associated with the prescribed treatment;
- Whether the parent has been informed about the availability of preventive health care services and how services can be obtained.

It must be verified that the child has/had an untreated health problem, or that a prescribed treatment plan was implemented. The verification must come from a physician, registered nurse, dentist, or by a direct admission from the alleged perpetrator. It must further be verified by a physician, registered nurse or dentist that the problem or condition, if untreated, could result in serious or long-term harm to the child.

81

Failure to Thrive (Non-Organic)

Failure to thrive is a serious medical condition most often seen in children under one year of age. The child's weight, height and motor development fall significantly short of the average growth rates of normal children (i.e., below the fifth percentile). In a small percentage of these cases, there is an organic cause such as a serious kidney, heart or intestinal disease, a genetic error of metabolism or brain damage. Usually in non-organic failure to thrive cases there is a disturbed parent/child relationship that manifests itself as physical and emotional neglect of the child. Diseases that may prevent growth and psychosocial reasons that cause growth failure are not mutually exclusive. They are often found together. Non-organic failure to thrive requires a medical diagnosis before it may be indicated.

Verification of failure to thrive must come from a physician who has the relevant information to make a diagnosis.

Factors That Must Be Present

- The infant or child's weight and head circumference do not match standard growth charts. The person's weight falls lower than 3rd percentile (as outlined in standard growth charts) or 20% below the ideal weight for his or her height.
- There is emotional deprivation as a result of parental withdrawal, rejection or hostility.
- The physician has made a diagnosis of failure to thrive after eliminating medical causes such as Down syndrome and Turner syndrome or diseases involving major organs (e.g., heart, kidney, intestinal).

82

Environmental Neglect

The child's person, clothing, or living conditions are unsanitary to the point that the child's health may be impaired. This may include infestations of rodents, spiders, insects, snakes, etc., human or animal feces, rotten or spoiled food or rotten or spoiled garbage that the child can reach.

Factors To Be Considered

Special attention should be paid to the child's physical condition and the living conditions in the home in order to determine whether the report constitutes an allegation of harm. In addition, the following factors should be considered.

Child Factors

- The child's age (children aged 6 and under are more likely to be harmed);

- The child's developmental stage;
- The child's physical condition;
- The child's mental abilities.

Incident Factors

- The severity of the conditions;
- The frequency of the conditions;
- The duration of the conditions;
- The chronicity or pattern of similar conditions.

83 **Malnutrition (Non-Organic)**

Malnutrition is the lack of necessary or proper food substances in the body caused by inadequate food, lack of food, or insufficient amounts of vitamin or minerals. This is also known as marasmus or kwashiorkor. Non-organic malnutrition requires a medical diagnosis before it may be indicated. There are various physical signs of malnutrition:

- A decrease in lean body mass or fat; very prominent ribs; the child may often be referred to as skin and bones;
- Hair is often sparse, thin, dry, and is easily pulled out or falls out spontaneously;
- The child is often pale and suffers from anemia;
- Excessive perspiration, especially about the head;
- The face appears lined and aged, often with a pinched and sharp appearance;
- The skin has an old, wrinkled look with poor turgor and typically skin folds hang loose on the inner thigh and buttock;
- The abdomen is often protuberant;
- There are abnormal pulses, blood pressure, stool patterns, intercurrent infections, abnormal sleep patterns and a decreased level of physical and mental activity.

Verification of malnutrition must come from a physician.

84 **Lock-Out**

The parent or caregiver has denied the child access to the home and has refused or failed to make provisions for another living arrangement for the child.

Medical Neglect of Disabled Infants

Medical neglect of a disabled infant is the withholding of appropriate nutrition, hydration, medication or other medically indicated treatment from a disabled infant with a life-threatening condition. Medically indicated treatment includes medical care that is most likely to relieve or correct all life-threatening conditions and evaluations or consultations necessary to assure that sufficient information has been gathered to make informed medical decisions. Nutrition, hydration and medication, as appropriate for the infant's needs, are medically indicated for all disabled infants. Other types of treatment are not medically indicated when:

- The infant is chronically and irreversibly comatose;
- The provision of the treatment would be futile and would merely prolong dying;
- The provision of the treatment would be virtually futile and the treatment itself would be inhumane under the circumstances.

In determining whether treatment will be medically indicated, reasonable medical judgments, such as those made by a prudent physician knowledgeable about the case and its treatment possibilities, will be respected. However, opinions about the infant's future "quality of life" are not to bear on whether a treatment is judged to be medically indicated.

Factors To Be Considered

- The infant's physical condition;
- The seriousness of the current health problem;
- The probable medical outcome if the current health problem is not treated and the seriousness of that outcome;
- The generally accepted medical benefits of the prescribed treatment;
- The generally recognized side effects associated with the prescribed treatment;
- The opinions of the Infant Care Review Committee (ICRC), if the hospital has an ICRC;
- The judgment of the Perinatal Coordinator regarding whether treatment is medically indicated and whether there is credible evidence of medical neglect;
- The parent's knowledge and understanding of the treatment and the probable medical outcome.

Verification that treatment was medically indicated must come from a physician and may come from experts in the field of neonatal pediatrics.

86

Neglect by Agency

Neglect by Agency means children or adult residents are exposed to harm, risk of harm or a lack of other necessary care that includes, but is not limited to:

- failure to provide adequate supervision;
- failure to provide food, clothing and shelter; or
- subjecting a child or adult resident to an environment that is injurious, as a result of the failure of an agency to implement practices that ensure the health, physical well-being, or welfare of the children or adult residents residing in the facility.

This neglect exists when there are conditions at the agency, such as inadequate staffing, lack of management training or lack of supervision of staff, that are to such an extent that staff culpability for abuse or neglect is mitigated by systemic problems. This neglect also includes instances in which an incident of abuse or neglect occurs against a child or adult resident and the perpetrator of such harm cannot be identified.

(Source: Amended at 41 Ill. Reg. 4681, effective April 21, 2017)

300.APPENDIX B – THE ALLEGATIONS SYSTEM

a) Purpose of the Allegation System

The allegations identify and define specific types of moderate to severe harm, provide a framework for decision-making by SCR and investigative staff, and provide an important investigation tracking and record-keeping function. To fulfill the purposes of the allegation-based system, it is essential that the allegations are narrowly defined and used consistently throughout the state. The Child Protection Specialist must refer to the specific allegation and the factors endemic to that allegation, to guide him/her in making a final finding.

Note: If investigative activities reveal an additional allegation is needed or a more appropriate allegation is needed to replace the allegation originally assigned, the Child Protection Specialist should identify and assign the most appropriate allegation.

b) Allegations

The allegation system defines moderate to severe harm or the risk of moderate to severe harm of a child. Many of the allegations are categorized as either abuse **or** neglect. All abuse allegations of harm are coded with a one or two-digit number, 40 and under. All neglect allegations of harm are coded with a two-digit number greater than 50. The allegations of harm are categorized and coded as follows:

ABUSE		NEGLECT	
#1	Death	#51	Death
#2	Head Injuries	#52	Head Injuries
#4	Internal Injuries	#54	Internal Injuries
#5	Burns	#55	Burns
#6	Poison/Noxious Substances	#56	Poison/Noxious Substances
#7	Wounds	#57	Wounds
#9	Bone Fractures	#59	Bone Fractures
#10	Substantial Risk of Physical Injury/Environment Injurious to Health and Welfare	#60	Substantial Risk of Physical Injury/Environment Injurious to Health and Welfare
#11	Cuts, Bruises, Welts, Abrasions and Oral Injuries	#61	Cuts, Bruises, Welts, Abrasions and Oral Injuries
#12	Human Bites	#62	Human Bites
#13	Sprains/Dislocations	#63	Sprains/Dislocations
#14	Tying/Close Confinement		Abuse Only

	ABUSE		NEGLECT
#15	Substance Misuse	#65	Substance Misuse
#16	Torture		Abuse Only
#17	Mental and Emotional Impairment	#67	Mental and Emotional Impairment
#18	Sexually Transmitted Diseases		Abuse Only
#19	Sexual Penetration		Abuse Only
#20	Sexual Exploitation		Abuse Only
#21	Sexual Molestation		Abuse Only
#22	Substantial Risk of Sexual Injury		Abuse Only
#40	Human Trafficking of Children	#90	Human Trafficking of Children
	Neglect Only	#74	Inadequate Supervision
	Neglect Only	#75	Abandonment/Desertion
	Neglect Only	#76	Inadequate Food
	Neglect Only	#77	Inadequate Shelter
	Neglect Only	#78	Inadequate Clothing
	Neglect Only	#79	Medical Neglect
	Neglect Only	#81	Failure to Thrive (Non-Organic)
	Neglect Only	#82	Environmental Neglect
	Neglect Only	#83	Malnutrition (Non-Organic)
	Neglect Only	#84	Lock-out
	Neglect Only	#85	Medical Neglect of Disabled Infants

c) Persons Who May Be Considered Perpetrators of Child Abuse or Neglect

The following guidelines clarify which persons may be considered perpetrators of child abuse or neglect.

RELATIONSHIP	ABUSE	NEGLECT
PARENTS		
Legal and/or Biological Parents (Includes Non-Custodial Parents)	X	X
Step Parents	X	X
Adoptive Parents	X	X

IMMEDIATE FAMILY MEMBERS		
Biological Brothers and Sisters	X	See Note
Step-Brothers and Sisters	X	See Note
Adopted Brothers and Sisters	X	See Note
Biological Grandfather and Grandmother	X	See Note
Step-Grandfather and Grandmother	X	See Note
Adopted Grandfather and Grandmother	X	See Note
INDIVIDUALS RESIDING IN THE SAME HOME AS THE CHILD		
May Include Foster Brothers and Sisters	X	See Note
(To determine residency, the person should maintain clothing and personal effects at the address, receive mail at or have identification using the address or otherwise identify the residence as his or her home. Visitors or short-term quests are not included in this category.)		
May Include Foster Brothers and Sisters	X	See Note
PARAMOUR		
Parent's "Boyfriend" or "Girlfriend"	X	See Note
"Paramour" means a significant other (e.g., boyfriend, girlfriend, lover, partner, friend or putative father) who is involved in an intimate/romantic relationship with one of the custodial parents of the children who come to the official attention of the Department through a child abuse or neglect investigation and/or open case; does not have a legally recognized and/or *significant, continuous and stable* relationship with *all* of the children; and may or may not live in the same household of the custodial parent of the involved children.		

PERSON RESPONSIBLE FOR THE CHILD'S WELFARE (CARETAKER)		
Legal Guardian of the Child	X	X
Foster Parents	X	X
Relative Caretakers	X	X
Day Care Home Caregivers (Regardless of whether licensed or license-exempt. Includes home other persons residing in the home.)	X	X
Day Care Center Employees (Includes all employees and volunteers who have direct contact with children)	X	X
Residential Care Facility Employees (Includes all employees and volunteers who have direct contact with children)	X	X
Other Caretakers or Baby-Sitters (When the child's parents or legal guardian has a verbal or written agreement for the person to assume responsibility for the child's care during the parent or guardian's absence. Includes home caregiver and other persons residing in the home.)	X	X
Other Persons Any other person responsible for the child's welfare at the time of the alleged abuse or neglect. Included in this category are health care professionals, educational personnel, recreational supervisors, and volunteers or support personnel in any setting where children may be subject to abuse or neglect.	X	X

Note: In accordance with ANCRA, an immediate family member, other person residing in the same home as the child or the parent's paramour cannot be alleged as the perpetrator of child neglect unless they were acting as the child's caretaker when the incident occurred.

d) Reasonable Effort to Protect a Child

ANCRA includes in its definition of abuse, *"persons who allow to be inflicted upon such child physical injury, by other than accidental means."* If a parent, caregiver, immediate family member, other person residing in the home, or the parent's paramour **fails to make reasonable effort** to protect a child from physical injury caused by other than accidental means, he/she can be an alleged perpetrator of **abuse,** rather than neglect. "Reasonable effort" refers to the effort a person responsible for the welfare of a child should be expected to make in order to protect a child, without posing an imminent threat to his or her safety.

Note: Minors are not expected to intervene between an adult and another child.

e) Harm or Imminent Risk of Harm Caused by the Blatant Disregard of Parental or Caregiver Responsibilities

"Blatant disregard" *means an incident where the real, significant, and imminent risk of harm would be so obvious to a reasonable parent or caretaker that it is unlikely that a reasonable parent or caretaker would have exposed the child to the danger without exercising precautionary measures to protect the child from harm.* [325 ILCS 5/3]

Example: A home daycare provider, with a pool or pond on their property, who fails to provide adequate supervision or take necessary precautions to prevent a child from drowning.

In addition to allegations #74-85, **neglect** is used for all allegations of harm that are attributable to **either** abuse or neglect. A child may sustain moderate to severe harm (e.g., brain damage, death, etc.) because of the **"blatant disregard"** of the parent or caregiver in his or her responsibility to oversee and protect the child. In such instances, the harm is the same to the child, however the cause is attributable to **neglect**, not abuse.

f) Special Assessments in Cases of Egregious Acts

The Department has identified certain acts of maltreatment deemed egregious that require a special assessment by the Office of Legal Services (OLS) and the Division of Clinical Practice and Professional Development. This special assessment will determine the need to by-pass reunification, seek a permanency goal other than reunification, and/or seek expedited termination of parental rights. If information identifying an egregious act is gathered at the time of the intake by SCR or during the course of the investigation, the report must be flagged as an egregious act case to alert the Child Protection Specialist and the Child Protection Supervisor that the case must be referred to OLS and Clinical. Maltreatment is considered egregious if it is an egregious, sadistic, or torturous act that inflicts significant pain, causes extensive external and/or internal bruising, serious injury, or death.

Egregious acts include:

- Perpetrator repeatedly thrown or slammed an infant or toddler against a hard surface using a strong degree of force creating a likelihood of abusive head trauma or multiple injuries including bruising or fractures over time.
- Perpetrator caused abusive abdominal injuries, especially in very young children.
- Perpetrator submerged and held a young child's head under water or repeatedly submerged a child's head creating a significant real or imminent risk of harm.
- Perpetrator beat up or hit a child with an object using a degree of force that could be reasonably expected to cause serious injury or death.
- Perpetrator attempted to or actually smothered, choked, strangled, or applied any other severe thoracic compression to a child.
- Perpetrator extensively burned or scalded a child on purpose.
- Perpetrator threatened or attacked a child with a weapon, such as a knife, gun, or combustible substance.
- Perpetrator took a child hostage.
- Sadistic injury to a child.
- Homicide of a child.
- Non-accidental poisoning.

g) Outline of an Allegation

While each allegation contained in this section is unique and identifies specific contacts, activities, factors to be considered, and documentation that must be applied and performed when investigating that specific allegation, there are certain contact, activities, and documentation the Child Protection Specialist must apply and perform for ALL allegations. These functions are listed below.

THE CHILD PROTECTION SPECIALIST AND SUPERVISOR MUST REVIEW EACH ALLEGATION TO DETERMINE IF THERE ARE SPECIFIC REQUIREMENTS OR INSTRUCTIONS FOR A SPECIFIC ALLEGATION.

For example: As a part of the initial contact with an alleged victim, the Child Protection Specialist is instructed to complete an assessment that includes photographs and a body chart for any injury or harm the victim may have. A Child Protection Specialist must NEVER photograph a victim of sexual abuse. The instructions for observing and assessing a child abuse victim are contained within those specific allegations.

The requirements and guidelines for completing investigations are outlined below. Each allegation contains the following information:

- **Definition of Allegation**
- **Taking a Report**

  Factors to be considered (Not applicable to all allegations)

- **Investigating the Report**

  Allegation Specific Required Contacts/Consultations
  Allegation Specific Required Activities
  Allegation Specific Required Documentation/Evidence
  Assessment of Factors and Evidence to Determine a Final Finding

h) Contacts, Activities, and Documentation Required for ALL Allegations

1) Required Contacts

All contacts and attempted contacts must be documented in a contact note within 48 hours.

A) Interview the reporter/source and other persons with information (OPWI) identified in the current report and related information reports.

B) Interview the alleged child victim(s) in person and individually. Complete an assessment that includes photographs and body chart of any physical injury or harm. Complete a safety assessment (**CERAP**) within 24 hours. Non-verbal children must be thoroughly observed and assessed.

However, the Child Protection Specialist should not interview the victim if, per local protocol, the case is Forensic Interview (FI) eligible or the victim is a child with developmental disabilities. The Child Protection Specialist shall refer the involved child to the local CAC for all FI, as soon as possible, if one has not already been conducted. If the victim is "unsafe," per the **CERAP**, every attempt must be made to arrange an emergency FI.

Note: Forensic Interviewers and Working with Child Advocacy Centers
Child Protection investigators play an important role with their Child Advocacy Center as part of a multidisciplinary team (MDT) approach. If possible, a multidisciplinary team approach to an investigation is preferred. When a Child Protection Specialist is also acting as a Forensic Interviewer for the team, the Child Protection Specialist must first complete 32 hours of approved

initial training and maintain a minimum of 8 hours continuing education every two years. To maintain Forensic Interviewer status, the Child Protection Specialist must also participate in the peer review process of their work twice yearly. As a member of an MDT, the Child Protection Specialist shall participate in monthly reviews of their cases. If not available, the Child Protection Supervisor should attend. To hone skills as part of an MDT, the Child Protection Specialist shall also participate in educational opportunities that are cross-discipline in nature. The Department shall designate a person who will be responsible for formalizing inter-agency agreements and policies across Child Advocacy Centers and MDTs.

Note: The Child Protection Specialist must ask the child if there is an extended family member, another adult or caretaker that he or she feels safe with, important or special to. If the child is interviewed by a Forensic Interviewer, the Child Protection Specialist shall coordinate with the Forensic Interviewer to ensure the child is asked if there is an extended family member, another adult or caretaker that he or she feels safe with, important or special to. Persons identified by the child victim shall be interviewed

C) Interview the parent/caregiver in person and individually. Efforts to interview a parent/caregiver must be attempted on the same day the children in the home are contacted, if possible. If a safety threat is determined to be present, the parent/caregiver must be interviewed immediately to continue to assess safety.

D) Interview in person and individually all other adults and verbal children in the **victim's** household. Non-verbal children must be thoroughly observed and assessed.

E) Conduct an interview with the alleged perpetrator in person and individually. The Child Protection Specialist should consult with law enforcement prior to the interview to avoid compromising any criminal investigation.

F) The Child Protection Specialist shall notify the custodial parent or legal caregiver of a child involved in the investigation of a facility or caregiver other than the parent. This includes the DCFS Guardianship Administrator if the child is a ward.

G) The Child Protection Specialist shall notify and interview the non-custodial parent.

H) Interview in person and individually all other adults and verbal children in the alleged **perpetrator's** household. Non-verbal children must be thoroughly observed and assessed.

I) Interview all identified witnesses that are reported to have information of the alleged incident.

J) Law enforcement shall be notified verbally and in writing (**CANTS 14**) within 24 hours of receipt of the report.

K) Notify the State's Attorney verbally and in writing within 24 hours of receipt of the report.

L) Interview the victim's primary medical provider as well as any other medical providers that have treated the child within the past twelve (12) months.

M) If the police have conducted an investigation, interview the police source in person or by telephone. DCFS and local law enforcement should cooperate in conducting investigations.

N) Interview paramedics called to the scene.

O) Interview hospital personnel with information if the victim was transported to a hospital for treatment.

P) Interview the DCFS or private agency worker if the family has an open service case or a service case that was closed.

Note: If a parenting ward is the subject of a pending and/or indicated investigation, TPSN must be notified.

Q) For those children enrolled in school or daycare, interview the children's school teachers, other school personnel and/or child care providers that have knowledge of the children and/or the level of care provided to the children.

R) Interview other professional collaterals who may have information of the child's injury that may be pertinent to the investigation.

S) The family or subjects should be asked to identify at least two (2) collateral contacts who must be interviewed either by telephone or in person.

T) Verbally notify and interview the Guardian ad Litem if the alleged child victim is a DCFS ward or a ward of the court (i.e., a child home with a parent under an order of protection).

U) Interview child protective services in other states where family members have resided.

V) Interview the DCFS nurse if the nurse has had prior involvement with the family.

W) Interview any social service professionals who have or had involvement with or knowledge of the child and/or family.

X) A waiver of any of the above requirements must be approved by the Child Protection Supervisor and may require approval by the Area Administrator. Details of the request and the Supervisor's decision must be documented in a supervisory note.

2) Required Activities

All investigative activities must be documented in a contact or case note within 48 hours.

A) The Child Protection Specialist shall complete a person search/**CANTS 19** and **within 48 hours** request a LEADS check of household members and other subjects regularly frequenting or living in the home. The Child Protection Specialist shall review LEADS for all subjects, including those involved in the safety assessment.

B) The Child Protection Specialist assigned an SOR of a pending investigation must contact and confer with the Child Protection Specialist of the pending investigation.

C) Thoroughly read and review prior indicated and, if available, unfounded investigations.

D) Observe and photograph the environment where the harm occurred and create a timeline. In addition to observing the environment, the Child Protection Specialist shall conduct a scene investigation, per **Procedures 300.60, Scene Investigation.**

E) A medical examination must be completed if required for the allegation and/or if injuries are observed or the child reports pain and/or injury. The Child Protection Specialist shall request that the treating physician or nurse photograph the injuries and complete a body diagram supplied by the hospital or use the **CANTS 2A/B**.

F) When a second medical opinion is needed, refer to **Procedures 300.100 Medical Requirements for Reports of Child Abuse and Neglect**.

G) Obtain medical documentation that the injury/harm will have immediate and/or long-term health effects on the child.

H) Obtain the child's medical records of his or her current treatment/diagnosis and relevant past treatment.

I) Whether or not the child's medical needs are related to the alleged incident, Child Protection Specialists must take the following actions when it is suspected that the child is in need of medical care.

i) Ensure that the parents seek immediate medical attention for their child. Contact the child's physician within 24 hours after seeing the child to confirm that the child has received medical care. The Child Protection Specialist should accompany the child to the medical provider, if possible. If the Child Protection Specialist is not able to accompany the child to the medical provider, he/she must contact the medical provider or facility to alert them that the child is coming and why the child is being seen by the medical provider.

ii) If the parent refuses or does not obtain medical assistance for the child, the Child Protection Specialist must **immediately** consult with his or her supervisor or Area Administrator to determine if the child should be taken into temporary protective custody to provide medical care. (See **Procedures 300.100(c)(2)(B)**)

iii) Call law enforcement for assistance, if necessary.

J) When the police have investigated the injury/harm to the child, the completed investigation by the police should be obtained and documented. If the police report is not available, use a contact note to document that the report has been requested and to include any verbal statements given by the police. Child Protection Specialists must also inquire about and document efforts to obtain other law enforcement reports on the subjects under investigation.

Note: Every effort should be made to coordinate investigative activities with local law enforcement.

K) The Child Protection Supervisor must review all police reports to ensure the reported findings do not conflict with previously documented information received verbally.

L) For all investigations where law enforcement is involved, a conference with Child Protection staff, DCFS Legal (if appropriate), the State's Attorney and law enforcement shall be convened to discuss the recommended finding. The Child Protection Specialist shall document the discussion of this conference in a contact note.

M) When there has been a prior indicated finding for serious abuse or a prior arrest or conviction of child endangerment or battery to a child and the parent/caregiver continues to permit the abuser to have access to the child, the Child Protection Specialist must attempt to secure the full investigative file from law enforcement prior to closing the investigation.

N) If multiple possible perpetrators are identified, document the evidence that pertains to each possible perpetrator.

O) The Child Protection Specialist shall complete the Domestic Violence and Substance Abuse screens on all eligible subjects. The Paramour Checklist is to be completed if the case is identified as a Paramour case.

P) If there is an open intact or placement service case and/or there are concurrent investigations, the Child Protection Specialist shall convene a conference for the purpose of reviewing the pending investigation with all professionals involved, including but not limited to, law enforcement, the State's Attorney office, medical professionals, and DCFS/POS staff. The Child Protection Specialist shall document the discussion of this conference in a contact note.

Q) A waiver of any of the above requirements must be approved by the Child Protection Supervisor and may require approval by the Area Administrator. Details of the request and the Supervisor's decision must be documented in a supervisory note.

3) Required Documentation

A) All documented medical diagnoses that are related to the injury/harm. Any medical records concerning the child's current treatment/diagnosis and relevant past treatment must be obtained.

B) If police involvement, police investigation case findings and reports generated by the police, as well as law enforcement photographs of the child's injuries and scene or other relevant evidence. If the police report is not available, use a contact note to document that the report has been requested and to include any verbal statements given by the police. The Child Protection Specialist must also inquire about and document efforts to obtain other law enforcement reports on the subjects under investigation. The Child Protection Specialist must make every effort to obtain the police report prior to closing the investigation.

C) Evidence that identifies the most likely perpetrator. If multiple, possible perpetrators are identified, document evidence that pertains to each possible perpetrator.

D) Documentation that all the LEADS reports were reviewed to determine the impact on safety and the final finding.

E) Documentation that all other required contacts have been made. If a contact has not been made, there are documented reasons for the situation.

F) Documentation of detailed, descriptive explanatory statements of the incident provided by the alleged perpetrator, victim, witnesses, and any other persons with knowledge of the injury/harm.

G) A waiver of any of the above requirements must be approved by the Child Protection Supervisor and may require approval by the Area Administrator. Details of the request and the Supervisor's decision must be documented in a supervisory note.

4) Assessment of Factors and Evidence to Determine a Final Finding

A) Documentation of a detailed analysis of all inculpatory and exculpatory evidence has been reviewed and considered and any conflicting evidence has been resolved to the extent possible.

B) The Child Protection Specialist and Child Protection Supervisor shall have a formal supervisory conference to assess all inculpatory and exculpatory evidence obtained during the course of the investigation to reach an investigative finding. Document the supervisory contact in a supervisory note.

i) Retention Schedule

Identifying information contained in indicated reports is retained in the State Central Register for 5, 20 or 50 years, depending on the allegation. If there are multiple indicated allegations in a report, all of the allegations will be retained for the longest length of time assigned to an allegation in that report. See **Procedures 300, Subsection 300.150(c)** for the schedule of case retention for indicated allegations as well as the retention schedule of unfounded reports.

j) References

Definitions of the allegations were taken in part from:

Taber's Cyclopedic Medical Dictionary. Edited by Clayton L. Thomas. M.D., M.P.H., Philadelphia: F.A. Davis Company, 1981.

Interdisciplinary Glossary on Child Abuse and Neglect: Legal, Medical, Social Work Terms, Washington, D.C.: U.S. Government Printing office, 1978.

Allegation of Harm #1/51
DEATH

a) Definition

Death

Death means the permanent cessation of all vital functions.

The following definitions of death are also commonly used:

- Total irreversible cessation of cerebral function, spontaneous function of the respiratory system, and spontaneous function of the circulatory system; and
- The final and irreversible cessation of perceptible heartbeat and respiration.

b) Taking a Report

The reporter/source has reason to believe that the child's death resulted from the following:

1) A direct action of the parent, caregiver, immediate family member, other person residing in the home, the parent's paramour, or other person responsible for the child's welfare (ABUSE);

2) The failure of the parent, caregiver, immediate family member, other person residing in the home, the parent's paramour, or other person responsible for the child's welfare to make reasonable efforts to stop an action by another person that resulted in the child's death (ABUSE); or

3) Blatant disregard of parental/caregiver responsibilities that resulted in the child's death (NEGLECT). "Blatant disregard" means an incident where the real, significant, and imminent risk of harm would be so obvious to a reasonable parent or caretaker that it is unlikely that a reasonable parent or caretaker would have exposed the child to the danger without exercising precautionary measures to protect the child from harm; [325 ILCS 5/3)]

When taking a report involving the death of a child, allegations #10 Substantial Risk of Physical Injury or #60 Environment Injurious are applicable only to surviving siblings or other children residing in the home and shall not be assigned to the deceased child.

c) Investigating a Report

1) Required Contacts

All contacts and attempted contacts must be documented in a contact note within 48 hours.

A) Immediate individual and in-person interviews with surviving siblings and other children that lived or were temporarily staying in the environment in which the child died must be completed. Complete a safety assessment (**CERAP**) within 24 hours. Interviews should be conducted using the Forensic Interview protocol. Non-verbal children must be thoroughly observed and assessed.

If there are additional children in the home that were not listed on the report, they must be added to the report, assigned an allegation (as necessary), and their safety and trauma/grief therapy needs must be assessed. The Child Protection Specialist shall evaluate the need for grief therapy for all family members.

Note: A child death, in and of itself, may not require removal of surviving children from the home.

Note: If other children in the home are considered to be at risk, they should be asked if he/she knows an extended family member, another adult or caretaker that he or she feels safe with or important or special to. Persons identified by the child victim shall be interviewed.

B) Notify and interview the victim's primary medical provider as well as any other medical providers that have treated the child within the past twelve (12) months. If multiple medical providers are identified, the Child Protection Specialist shall share all information provided with the Primary Care Physician.

C) Interview the coroner/medical examiner to obtain his/her preliminary finding of the cause and manner of the child's death. After obtaining the autopsy report, scene investigation, any relevant laboratory test results, and a coroner's inquest report (if an inquest was conducted), a subsequent interview of the coroner/medical examiner should be conducted, if necessary, to understand the findings.

D) A waiver of any of the above requirements must be approved by the Child Protection Supervisor and may require approval by the Area Administrator. Details of the request and the Supervisor's decision must be documented in a supervisory note.

2) Required Activities

All investigative activities must be documented in a contact or case note within 48 hours.

In areas served by a Child Advocacy Center, investigations must be coordinated with the center if the center is willing to work with this allegation.

A) Observe and photograph the environment where the alleged incident of harm occurred and create a timeline. The coroner/medical examiner has primary responsibility to conduct the scene investigation. The Child Protection Specialist shall conduct a scene investigation when the coroner/medical examiner and law enforcement have not already done so. The Child Protection Specialist shall conduct the scene investigation per **Procedures 300.60, Scene Investigation.**

B) Medical examinations of all other children residing full or part-time in the home where the child died are required. These medical exams may not be waived. See **Procedures 300.100, Medical Requirements for Reports of Child Abuse and Neglect**, for further instruction.

C) Obtain reports completed by the attending physician, coroner/medical examiner regarding the cause and manner of the child's death including autopsy report, scene investigation, any relevant laboratory test results, and coroner's inquest report (if an inquest was conducted). Include medical records of surviving children, if potentially relevant to the final determination.

D) Child Protection Specialists, in consultation with the Child Protection Supervisor, must complete a safety assessment of all other children living or temporarily staying in the environment where the child died. The Specialist shall take appropriate action based on the finding of the safety assessment in accordance with **Procedures 300, Appendix G (CERAP)**.

E) During a death investigation, when an infant should be wearing an apnea monitor, the Child Protection Specialist shall request that the doctor who ordered the apnea monitor request from the apnea monitor company the records for that monitor's use during the relevant time periods.

F) The supervisor must review the autopsy report prior to the final finding to ensure that the autopsy findings do not conflict with previously documented information received verbally.

G) A waiver of any of the above requirements must be approved by the Child Protection Supervisor and may require approval by the Area Administrator. Details of the request and the Supervisor's decision must be documented in a supervisory note.

3) Required Documentation

A) Autopsy report, scene investigation, any relevant laboratory test results, and coroner's inquest report (if an inquest was conducted). If these are unavailable, the Child Protection Specialist must attempt to obtain the death certificate or medical report of the child's death.

B) Medical reports concerning any medical procedure the child received just prior to his or her death and any relevant medical reports concerning past treatment the child received.

C) If available, law enforcement or coroner photographs of the child's fatal injuries.

D) Police investigation case findings and reports generated by the police. If the police report is not available, use a contact note to document that the report has been requested and to include any verbal statements given by the police. The Child Protection Specialist must also inquire about and document efforts to obtain other law enforcement reports on the subjects under investigation. The Child Protection Specialist must make every effort to obtain the police report prior to closing the investigation.

E) To make a finding of abuse (**Allegation #1**), documentation has been obtained that verifies that the child's death is a result of a direct action of the perpetrator, or the perpetrator has admitted to killing the child. The Child Protection Specialist and Supervisor must review the medical documentation to ensure report findings do not conflict with medical opinion.

F) To make a finding of neglect (**Allegation #51**), documentation has been obtained that verifies the child's death is the result of blatant disregard by an eligible perpetrator.

G) A waiver of any of the above requirements must be approved by the Child Protection Supervisor and may require approval by the Area Administrator. Details of the request and the Supervisor's decision must be documented in a supervisory note.

4) Assessment of Factors and Evidence to Determine a Final Finding

A) Factors include:

i) Did the child's death result from:

- A direct action of the parent, caregiver, immediate family member, other person residing in the home, the parent's paramour, or other person responsible for the child's welfare?; or

- The failure of the parent, caregiver, immediate family member, other person residing in the home, the parent's paramour, or other person responsible for the child's welfare to make reasonable efforts to stop an action by another person that resulted in the child's death?

ii) Did the parent or caregiver exhibit 'blatant disregard'?

B) A current report involving the same subjects of an unfounded report shall not be indicated solely on the basis of the prior unfounded report. If new details provide information that could impact a previously unfounded investigation, the information must be reported to the SCR to determine if a new investigation of the unfounded allegation is warranted.

C) When making a final finding determination for **Allegation #1/#51 Death, Allegations #10 Substantial Risk of Physical Injury, or #60 Environment Injurious** may be applicable to surviving siblings or other children residing in the home, but shall not be assigned to the deceased child.

D) Coroners/Medical Examiners are limited to ***5 manners*** of death:

- Homicide;
- Suicide;
- Natural;
- Undetermined, and
- Accidental

The "manner" of death does not rule out the possibility of child abuse and/or neglect. The Child Protection Specialist and Child Protection Supervisor need to assess all of the evidence to make that determination.

Example: An accidental manner of death does not rule out the possible existence of child abuse or neglect (e.g., an intoxicated mother accidentally hits her child with her vehicle. The manner of death is ruled "accident"; however, the mother was neglectful in driving while intoxicated).

Example: A manner of death of undetermined occurs in cases in which there is insufficient information to classify the death as a homicide, accident, natural or suicide. A manner of death of undetermined does not rule out the possible existence of child abuse or neglect (e.g., a child has the presence of non-accidental bruises at the time of death).

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Allegation of Harm #2/52
HEAD INJURIES

a) Definition

Head Injuries

Head injuries are serious injuries causing skull fracture, brain damage or bleeding on the brain such as a subdural hematoma or **Abusive Head Trauma** (Shaken Baby Syndrome).

Brain Damage – Option A

Direct damage to the brain from blunt or penetrating force or secondary to lack of oxygen (suffocation).

Skull Fracture – Option B

A skull fracture is a break of the bone surrounding the brain. The fracture pattern possibilities include linear or comminuted (more than one fracture). A fracture may be described as depressed which means the bone fragment is displaced.

Hematoma – Option C

Hematomas are collections of blood outside blood vessels which are injured. Depending on the location of the bleeding, the following types of hematomas result:

- Subgaleal hematomas are located outside the skull. They can be seen as a bump or swelling to the scalp.
- Epidural hematomas occur right under the skull bone; therefore they are intracranial or inside the skull. They can occur from impact to the temporal or side of the head. Blood vessels running under the fracture are severed and blood accumulates under the fracture above the dura mater.
- Subdural hematomas are collections of blood beneath the dura mater (the tough outer membrane covering the spinal cord and brain).
- Subarachnoid hematomas are blood collections below another layer of tissue surrounding the brain called the subarachnoid layer.

Abusive Head Trauma - Option D
(Shaken Baby Syndrome or Shaken Impact Syndrome)

- Abusive head trauma means an injury to the head, especially to the scalp and cranium that may be limited to soft tissue damage or may include the cranial bones, eye sockets, and the brain, including any of the types of hematomas.

- "Violent whiplash-type shaking injury inflicted by an abuser." Shaking of an infant may cause coma, convulsions and increased intracranial pressure, resulting in stretching and tearing of the cerebral veins with consequent bleeding into the subdural space. These injuries may occur with or without obvious evidence of impact to the cranium; however retinal hemorrhages and bruises on the arms or trunk are sometimes present.

b) Taking a Report

The reporter/source has reason to believe that the head injury resulted from one of the following:

1) A direct action of the parent, caregiver , immediate family member, other person residing in the home, the parent's paramour or other person responsible for the child's welfare (ABUSE);

2) The failure of the parent, caregiver, immediate family member, other person residing in the home, the parent's paramour, or other person responsible for the child's welfare to make reasonable efforts to stop an action by another person which resulted in the child sustaining a head injury (ABUSE); or

3) Blatant disregard of parental/caregiver responsibilities that resulted in the child sustaining a head injury (NEGLECT).

c) Investigating a Report

1) Required Contacts

All contacts and attempted contacts must be documented in a contact note within 48 hours.

There are no additional contacts specific to this allegation.

2) Required Activities

All investigative activities must be documented in a contact or case note within 48 hours.

In areas served by a Child Advocacy Center, investigations must be coordinated with the center if the center is willing to work with this allegation.

A medical examination of the child is required for this allegation and shall not be waived if the child is an infant, is non-verbal, or is developmentally delayed. This allegation cannot be unfounded without a medical examination and consultation. The Child Protection Specialist shall request that the treating physician or nurse photograph the injuries and complete a body diagram supplied by the hospital or use the **CANTS 2A/B**.

3) Required Documentation

A) Documented medical diagnosis that the head injury exists and an exact description of the injury. Medical records concerning the child's current treatment/diagnosis and relevant past treatment must be obtained.

B) Verification of head injuries and the presence or absence of any predisposing medical condition that may have caused or contributed to the injuries must come from a physician

C) Medical reports concerning any medical procedure the child received just prior to injury and any relevant medical reports concerning past treatment the child received, if any.

D) To make a finding of abuse (**Allegation #2**), documentation has been obtained that verifies that the child sustained a head injury as a result of a direct action of the perpetrator, or the perpetrator has admitted to injuring the child.

E) To make a finding of neglect (**Allegation #52**), documentation has been obtained that verifies the child sustained a head injury as a result of blatant disregard by an eligible perpetrator.

F) A waiver of any of the above requirements must be approved by the Child Protection Supervisor and may require approval by the Area Administrator. Details of the request and the Supervisor's decision must be documented in a supervisory note.

4) Assessment of Factors and Evidence to Determine a Final Finding

There are no additional factors specific to this allegation.

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Allegation of Harm #4/54
INTERNAL INJURIES

a) Definition

Internal Injury

An internal injury is an injury that is not visible from the outside (e.g. an injury to the organs occupying the thoracic or abdominal cavities). Such injury may result from a direct blow or a penetrating injury. Internal injuries include injuries to the lungs, heart, spleen, kidneys, adrenal glands, liver, stomach, pancreas, intestines, or bladder.

A person with internal injuries will look ill, may vomit, be unable to take in fluids, and will progressively become worse. Signs of injury include vomiting, decreased alertness, and internal bleeding.

b) Taking a Report

The reporter/source has reason to believe that the internal injuries resulted from one of the following:

1) A direct action of the parent, caregiver , immediate family member, other person residing in the home, the parent's paramour or other person responsible for the child's welfare (ABUSE);

2) The failure of the parent, caregiver, immediate family member, other person residing in the home, the parent's paramour, or other person responsible for the child's welfare to make reasonable efforts to stop an action by another person which resulted in internal injuries (ABUSE); or

3) Blatant disregard of parental/caregiver responsibilities that resulted in the child sustaining internal injuries (NEGLECT).

c) Investigating a Report

1) Required Contacts

All contacts and attempted contacts must be documented in a contact note within 48 hours.

There are no additional contacts specific to this allegation.

2) Required Activities

All investigative activities must be documented in a contact or case note within 48 hours.

In areas served by a Child Advocacy Center, investigations must be coordinated with the center if the center is willing to work with this allegation.

A) A medical examination of the child is required for this allegation and shall not be waived if the child is an infant, is non-verbal, or is developmentally delayed. The Child Protection Specialist should request that the treating physician or nurse complete a diagram supplied by the hospital or use the **CANTS 2A/B**.

B) A waiver of any of the above requirements must be approved by the Child Protection Supervisor and may require approval by the Area Administrator. Details of the request and the Supervisor's decision must be documented in a supervisory note.

3) Required Documentation

A) Documented medical diagnosis that an internal injury exists and there is an exact description of the injury and all other relevant medical records.

B) To make a finding of abuse (**Allegation #4**), documentation has been obtained that verifies that the child sustained an internal injury as a result of a direct action of the perpetrator, or the perpetrator has admitted to harming the child. The Child Protection Specialist and Supervisor must review the medical documentation to ensure report findings do not conflict with medical opinion.

C) To make a finding of neglect (**Allegation #54**), documentation has been obtained that verifies the child sustained an internal injury as a result of blatant disregard by an eligible perpetrator.

D) A waiver of any of the above requirements must be approved by the Child Protection Supervisor and may require approval by the Area Administrator. Details of the request and the Supervisor's decision must be documented in a supervisory note.

4) Assessment of Factors and Evidence to Determine a Final Finding

There are no additional factors specific to this allegation.

Allegation of Harm #5/55
BURNS

a) Definition

Burns

Burns are tissue injuries resulting from excessive exposure to thermal (heat or cold), chemical, electrical or radioactive agents. The effects vary according to the type, duration and intensity of the agent and the part of the body involved. Burns are usually classified as first, second, third or fourth degree.

- **First Degree** (Superficial Partial Thickness)

  First degree burns are superficial burns in which damage is limited to the outer layer of the epidermis (skin) and are characterized by scorching or painful redness of the skin. Sunburn is an example of a first degree burn.

- **Second Degree** (Full Partial Thickness)

  Second degree burns are burns in which the damage extends through the outer layer of the skin into the inner layers (dermis). Blistering will be present within 24 hours.

- **Third Degree** (Full Thickness)

  Third degree burns are burns in which both layers of skin (epidermis and dermis) are destroyed with damage extending into underlying tissues. Tissue may be charred or coagulated.

- **Fourth Degree** (Full Thickness)

  Fourth degree burns are burns that extend beyond skin and underlying tissues into bone, joints and muscles.

- **Scalding**

  Scalding is a burn to the skin or flesh caused by moist heat and hot vapors, such as steam.

b) Taking a Report

The reporter/source has reason to believe that the burn or scalding resulted from one of the following:

1) A direct action of the parent, caregiver, immediate family member, other person residing in the home, the parent's paramour, or other person responsible for the child's welfare (ABUSE);

2) The failure of the parent, caregiver, immediate family member, other person residing in the home, the parent's paramour, or other person responsible for the child's welfare to make reasonable efforts to stop an action by another person which resulted in the burn or scalding (ABUSE); or

3) Blatant disregard of parental or caregiver responsibilities that resulted in the child sustaining a burn or scalding (NEGLECT).

c) Investigating a Report

1) Required Contacts

All contacts and attempted contacts must be documented in a contact note within 48 hours.

There are no additional contacts specific to this allegation.

2) Required Activities

All investigative activities must be documented in a contact or case note within 48 hours.

A) A medical examination of the child's injury is required for this allegation and shall not be waived if the child is an infant, is non-verbal, or is developmentally delayed. The Child Protection Specialist should request that the treating physician or nurse complete a diagram supplied by the hospital or use the **CANTS 2A/B**.

B) A waiver of any of the above requirements must be approved by the Child Protection Supervisor and may require approval by the Area Administrator. Details of the request and the Supervisor's decision must be documented in a supervisory note.

3) Required Documentation

A) Documented medical diagnosis that the child was burned and all relevant medical reports.

B) To make a finding of abuse, **Allegation #5**, documentation has been obtained that verifies the child's injuries are inconsistent with the explanation given and the most likely manner in which they occurred was by abuse. The Child Protection Supervisor must review the medical documentation to ensure report findings do not conflict with medical opinion.

C) To make a finding of neglect, **Allegation #55**, documentation has been obtained that verifies the child was burned as a result of blatant disregard by an eligible perpetrator.

D) A waiver of any of the above requirements must be approved by the Child Protection Supervisor and may require approval by the Area Administrator. Details of the request and the Supervisor's decision must be documented in a supervisory note.

4) Assessment of Factors and Evidence to Determine a Final Finding

There are no additional factors specific to this allegation.

Allegation of Harm #6/56
POISON/NOXIOUS SUBSTANCES

a) Definition

Poison

A poison is any substance, other than mood altering chemicals or alcohol, taken into the body by ingestion, inhalation, injection, or absorption that interferes with normal physiological functions. Virtually any substance can be poisonous if consumed in sufficient quantity; therefore, the term poison more often implies an excessive amount rather than the existence of a specific substance.

Noxious

A noxious substance is any substance deemed to be harmful (injurious); not wholesome.

Note: Ingestion of mood altering chemicals or alcohol should be coded as allegation of harm **#15/65, Substance Misuse**.

Note: In cases of suspected Medical Child Abuse, refer to **Procedures 300, Appendix L.**

b) Taking a Report

The reporter/source has reason to believe that a child was poisoned or ingested a noxious substance as the result of one of the following:

1) A direct action of the parent, caregiver, immediate family member, other persons residing in the home, the parent's paramour, or other person responsible for the child's welfare (ABUSE);

2) The failure of the parent, caregiver, immediate family member, other person residing in the home, the parent's paramour, or other person responsible for the child's welfare to make reasonable efforts to stop an action by another person which resulted in the child consuming poison or a noxious substance (ABUSE); or

3) Blatant disregard of parental/caregiver responsibilities that resulted in the child consuming poison or a noxious substance (NEGLECT).

c) Investigating a Report

1) Required Contacts

All contacts and attempted contacts must be documented in a contact note within 48 hours.

There are no additional contacts specific to this allegation.

2) Required Activities

All investigative activities must be documented in a contact or case note within 48 hours.

A) A medical examination of the child is required for this allegation and shall not be waived if the child is an infant, is non-verbal, or is developmentally delayed. The Child Protection Specialist should request that the treating physician or nurse complete a diagram supplied by the hospital or use the **CANTS 2A/B**.

B) A waiver of any of the above requirements must be approved by the Child Protection Supervisor and may require approval by the Area Administrator. Details of the request and the Supervisor's decision must be documented in a supervisory note.

3) Required Documentation

A) Documented medical diagnosis that the child was poisoned or was exposed to a noxious substance and all relevant medical records.

B) To make a finding of abuse (**Allegation #6**), documentation has been obtained that verifies that the child's consumption of or exposure to a poison or noxious substance was a result of a direct action of the perpetrator, or the perpetrator has admitted to poisoning the child. The Child Protection Specialist and Supervisor must review the medical documentation to ensure report findings do not conflict with medical opinion.

C) To make a finding of neglect (**Allegation #56**), documentation has been obtained that verifies the child ingested or was exposed to a poison or noxious substance as a result of blatant disregard by an eligible perpetrator.

D) A waiver of any of the above requirements must be approved by the Child Protection Supervisor and may require approval by the Area Administrator. Details of the request and the Supervisor's decision must be documented in a supervisory note.

4) Assessment of Factors and Evidence to Determine a Final Finding

There are no additional factors specific to this allegation.

Allegation of Harm #7/57
WOUNDS

a) Definition

Wounds

Wounds are gunshot or stabbing injuries.

b) Taking a Report

The reporter/source has reason to believe that the wound resulted from one of the following:

1) A direct action of the parent, caregiver, immediate family member, other person residing in the home, the parent's paramour, or other person responsible for the child's welfare (ABUSE);

2) The failure of the parent, caregiver , immediate family member, other person residing in the home, the parent's paramour, or other person responsible for the child's welfare to make reasonable efforts to stop an action by another person which resulted in a wound (ABUSE); or

3) Blatant disregard of parental/caregiver responsibilities that resulted in the child sustaining a wound (NEGLECT).

c) Investigating a Report

1) Required Contacts

All contacts and attempted contacts must be documented in a contact note within 48 hours.

There are no additional contacts specific to this allegation.

2) Required Activities

All investigative activities must be documented in a contact or case note within 48 hours.

A) A medical examination of the child is required for this allegation and shall not be waived if the child is an infant, is non-verbal, or is developmentally delayed. The Child Protection Specialist should request that the treating physician or nurse complete a diagram supplied by the hospital or use the **CANTS 2A/B**.

B) A waiver of any of the above requirements must be approved by the Child Protection Supervisor and may require approval by the Area Administrator. Details of the request and the Supervisor's decision must be documented in a supervisory note.

3) Required Documentation

A) Documented medical diagnosis that the child was wounded and all relevant medical records.

B) To make a finding of abuse (**Allegation #7**), documentation has been obtained that verifies that the child was wounded as a result of a direct action of the perpetrator, or the perpetrator has admitted to wounding the child. The Child Protection Specialist and Supervisor must review the medical documentation to ensure report findings do not conflict with medical opinion.

C) To make a finding of neglect (**Allegation #57**), documentation has been obtained that verifies the child was wounded as a result of blatant disregard by an eligible perpetrator.

D) A waiver of any of the above requirements must be approved by the Child Protection Supervisor and may require approval by the Area Administrator. Details of the request and the Supervisor's decision must be documented in a supervisory note.

4) Assessment of Factors to Determine a Final Finding

There are no additional factors specific to this allegation.

Allegation of Harm #9/59
BONE FRACTURES

a) Definition

Fracture

A fracture is a break in a bone or a cartilage injury, such as a broken nose.

There are different types of fractures which result from different forces applied to the bone that are great enough to lead to failure of the bone, resulting in fractures.

Transverse

A Transverse fracture is a fracture that results in a break through the bone; both sides of the bone are broken.

Greenstick

A Greenstick fracture is a bending fracture unique in children and in which one side of the bone is fractured.

Oblique and Spiral

Oblique and Spiral fractures are fractures where twisting is involved. Oblique means the fracture runs on an angle to the long bone. A spiral fracture implies that the twisting fracture is in the distribution like the lines of a barbershop stripe. On X-ray, oblique and spiral fractures look the same.

Torus (Buckle)

A Torus (Buckle) fracture is a compression fracture where the bone is compressed along the axis of the bone.

Salter Harris

Salter Harris fractures have to do with injury to the growth plate. These fractures are seen more often in older children.

Displaced

A Displaced fracture is when the bone parts are not in normal alignment.

Comminuted

A Comminuted fracture means the fracture has fragments.

b) Taking a Report

The reporter/source has reason to believe that the bone fracture resulted from one of the following:

1) A direct action of the parent, caregiver , immediate family member, other person residing in the home, the parent's paramour or other person responsible for the child's welfare (ABUSE);

2) The failure of the parent, immediate family member, other person residing in the home, the parent's paramour, or other person responsible for the child's welfare to make reasonable efforts to stop an action by another person which resulted in a bone fracture (ABUSE); or

3) Blatant disregard of parental/caregiver responsibilities that resulted in the child sustaining a bone fracture (NEGLECT).

c) Investigating a Report

1) Required Contacts

All contacts and attempted contacts must be documented in a contact note within 48 hours.

There are no additional contacts specific to this allegation.

2) Required Activities

All investigative activities must be documented in a contact or case note within 48 hours.

A) A medical examination of the child is required for this allegation and shall not be waived if the child is an infant, is non-verbal, or is developmentally delayed. The Child Protection Specialist should request that the treating physician or nurse complete a diagram supplied by the hospital or use the **CANTS 2A/B**.

B) A waiver of any of the above requirements must be approved by the Child Protection Supervisor and may require approval by the Area Administrator. Details of the request and the Supervisor's decision must be documented in a supervisory note.

3) Required Documentation

A) Documented medical diagnosis that the child sustained a broken bone and all relevant medical records.

B) To make a finding of abuse, (**Allegation #9**), documentation has been obtained that verifies the child's fracture is inconsistent with the explanation given and the most likely manner in which it occurred was by abuse; or the perpetrator has admitted causing the injury. The Child Protection Supervisor must review the medical documentation to ensure report findings do not conflict with medical opinion.

C) To make a finding of neglect, (**Allegation #59**), documentation has been obtained that verifies the child received a bone fracture as a result of blatant disregard by an eligible perpetrator.

D) A waiver of any of the above requirements must be approved by the Child Protection Supervisor and may require approval by the Area Administrator. Details of the request and the Supervisor's decision must be documented in a supervisory note.

4) Assessment of Factors and Evidence to Determine a Final Finding

There are no additional factors specific to this allegation.

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Allegation of Harm #10
SUBSTANTIAL RISK OF PHYSICAL INJURY

a) Definition

Substantial risk of physical injury means that the parent, caregiver immediate family member aged 16 or over, other person residing in the home aged 16 or over, or the parent's paramour has created a **real and significant danger** of physical injury. This allegation of harm is to be used when the type or extent of harm is undefined but the total circumstances lead a reasonable person to believe that the child is in substantial risk of physical injury.

Option A – Incidents of Violence or Intimidation

This option includes incidents of violence or intimidation directed toward a child which is not known to have resulted in injury or impairment, but which clearly threaten such injury or impairment. Examples of violence or intimidation include, but are not limited to:

- Strangling a child;
- Smothering a child;
- Pulling a child's hair out;
- Violently pushing or shoving the child;
- Throwing or shaking a small child;
- Other violent or intimidating act directed toward the child to cause pain or fear.
- Subjecting the child to participation in or witnessing the physical abuse or restraint of another person when it is used by the perpetrator to intimidate the child (e.g., this could happen to you, this will happen to you); or
- Other violent or intimidating acts directed toward the child or in close proximity of the child that cause excessive pain or fear.

Option B – Medical Child Abuse
(Factitious Disorder by Proxy or Munchausen by Proxy Syndrome)

Medical Child Abuse is a form of child harm that is characterized by a parent/caregiver who intentionally and persistently lies, fakes, and/or produces illness in the child and repeatedly presents the child for medical assessment/treatment.

Note: If during the course of the investigation, a specific allegation of harm is identified, the appropriate allegation shall be added and a determination made on all the allegations. If the living circumstances of the family lead the Child Protection Specialist to consider temporary protective custody, **Allegation #76 (Inadequate Food), #77 (Inadequate Shelter), #78 (Inadequate Clothing)** or **#82 (Environmental Neglect)** must be added and a determination made as to whether services to meet these basic needs will alleviate the need for temporary protective custody.

Examples of incidents or circumstances that in and of themselves do not constitute "risk of harm":

- Use of physical corporal punishment in and of itself does not constitute an allegation of substantial risk.
- Birth of a baby to families involved with the Department does not in and of itself constitute a substantial risk of harm or the presence of a real and significant danger.

b) Taking a Report

The reporter/source must have reason to believe that the incident/circumstances, that create a risk of harm, resulted from the following:

1) A direct action of the parent, caregiver, immediate family member, other person residing in the home, the parent's paramour, or other person responsible for the child's welfare (ABUSE);

2) The failure of the parent, caregiver, immediate family member, other person residing in the home, the parent's paramour, or other person responsible for the child's welfare to make reasonable efforts to stop an action by another person which resulted in substantial risk of harm to the child (ABUSE); or

3) One circumstance alone may present sufficient danger to justify taking the report. Examples of circumstances that can cause a substantial risk of physical injury include, but are not limited to:

   Circumstances

   - A perpetrator of child abuse who has been ordered by a court to remain out of the home returns home and has access to the children;
   - Anyone living in the home has a documented history of violence toward children or has been arrested for violence to a child;
   - Domestic violence in the home when the child or other family member has been threatened and the threat is believable, as evidenced by a past history of violence or uncontrolled behavior on the part of the perpetrator;

- Allowing or encouraging a child to be involved in a criminal activity; or
- The circumstances surrounding the death or serious injury of one child provide reason to believe that another child is at real and significant risk of harm.

c) Investigating a Report

1) Required Contacts

All contacts and attempted contacts must be documented in a contact note within 48 hours.

A) Law enforcement shall be notified verbally and in writing (**CANTS 14**), as needed and in consultation with the supervisor. **If Medical Child Abuse is alleged, law enforcement must be notified within 24 hours and copies of all applicable police reports involving persons in the child's house must be obtained.**

B) Notify the State's Attorney verbally and in writing, as needed and in consultation with the supervisor. **If Medical Child Abuse is alleged, the State's Attorney must be notified and provided with all available medical records, copies of investigative activities, and comparison investigative information.**

C) A waiver of any of the above requirements must be approved by the Child Protection Supervisor and may require approval by the Area Administrator. Details of the request and the Supervisor's decision must be documented in a supervisory note.

2) Required Activities

All investigative activities must be documented in a contact or case note within 48 hours.

A) If a child has special health care needs, as defined in **Procedures 302, Appendix O, Referral for Nursing Consultation Services**, the Child Protection Specialist must complete a DCFS nurse referral.

B) If Medical Child Abuse is suspected, schedule and convene a meeting with Department nursing staff to discuss the case, notify law enforcement and schedule a multidisciplinary team meeting with the involved medical staff and law enforcement.

C) Child Protection Supervisors are required to do the following for all cases where Medical Child Abuse is alleged:

- Notify the Area Administrator of the pending investigation;
- Conduct in person weekly supervision sessions with the assigned Child Protection Specialist. Sessions should be conducted more frequently if necessary; and
- Supervisory sessions must address safety assessment and planning, multidisciplinary team meetings, coordination and comparison of investigative information, and other pertinent information.

D) A waiver of any of the above requirements must be approved by the Child Protection Supervisor and may require approval by the Area Administrator. Details of the request and the Supervisor's decision must be documented in a supervisory note.

3) Required Documentation

A) Documentation and evidence that a child was subjected to substantial risk of injury and any relevant medical records.

B) A waiver of any of the above requirements must be approved by the Child Protection Supervisor and may require approval by the Area Administrator. Details of the request and the Supervisor's decision must be documented in a supervisory note.

4) Assessment of Factors and Evidence to Determine a Final Finding

A) If Medical Child Abuse is alleged, ensure that appropriate evidence has been obtained to answer the following questions:

- If the child's symptoms are suspected of being induced, how were they induced?
- If the child' symptoms were chemically induced, how long after the child was given the chemical would the symptoms appear? How long would the symptoms last?
- What was the circumstance or circumstances of the onset of the child's symptoms?
- Who was present with the child prior to the onset of the symptoms?

- Is there evidence in the child's or siblings' medical records of false reporting of illnesses?
- Has the child been hospitalized on multiple occasions with uncommon presenting symptoms?
- Has blood found in the child's stool or urine matched the child's blood type?
- Has potassium, acetaminophen, aspirin, insulin, prescription medication, diuretics, controlled substances, illegal drugs, arsenic, other toxic substances or chemicals been found in the child's blood, urine or stool?
- Did the child's reported medical symptoms improve while the child was hospitalized, and then reoccur after the child was discharged from the hospital?
- What are the ages of the involved children?
- Does the victim have a medical condition, behavioral, mental/emotional problem or disability that impacts his/her her ability to seek help or significantly increases the caregiver's stress level?
- Is there a pattern of similar instances with this child or other children for whom the caregiver is responsible?
- What is the severity of the incident of Substantial Risk or Environment Injurious?
- What is the location or nature of potential harm?
- Was an instrument or weapon used on the victim? The use of an instrument does not, in and of itself, constitute an indicated finding but must be considered with other factors.
- Is there a previous history of abuse or neglect? The history must be verifiable in SCR, through official record documentation, or substantial corroboration by other credible sources.
- What dynamics are present between the victim and the parent? Identify the child's level of fear of the caregiver. Does the caregiver appear to be concerned about the child's welfare and protection? Is there an appropriate parent/caregiver/child relationship?

B) Domestic Violence

- There is a history of past incidents of domestic violence as confirmed through interviews family with members, collateral contacts, police and LEADS reports.
- What is the nature of the domestic violence (e.g., yelling and screaming vs. physical contact or injury)?
- Have weapons been used or brandished?
- What is the involvement of the children during domestic violence incidents (e.g., present in the immediate vicinity, attempted to intervene, or out of immediate area)?
- Does the victim of domestic violence have the ability or wherewithal to use a support system?

C) Information Concerning Mental Health Issues

- What is the nature of the clinical diagnosis, if there is one?
- Is the nature of the illness such that medication controls inappropriate or harmful behaviors? If so, what is the level of medication compliance?
- Do the caregiver's hallucinations or delusions negatively affect the child and/or the caregiver's s ability to provide child care?
- Is there is a history of psychiatric hospitalizations?
- What is the history of the caregiver's treatment and treatment compliance history?
- Complete an assessment of the caregiver's parenting ability based on past parenting history.

D) Substance Abuse Issues

Identify substance use issues involving the parents or household members, and if they have involvement in the manufacture and distribution of illegal drugs.

Allegation of Harm 60
ENVIRONMENT INJURIOUS TO HEALTH AND WELFARE

a) Definition

An **Environment Injurious to Health and Welfare** is when there are conditions that create a real, significant, and imminent likelihood of harm to a child's health, physical well-being, or welfare **and** that the likelihood of harm is the result of the parent/caregiver's blatant disregard of his/her responsibility to exercise reasonable precautionary measures to prevent or mitigate the imminent risk of moderate to severe harm.

"Blatant disregard" is *an incident where the real, significant and imminent risk of harm would be so obvious to a reasonable parent or caretaker that it is unlikely that a reasonable parent or caretaker would have exposed the child to the danger without exercising precautionary measures to protect the child from harm.* [325 ILCS 5/3]

Circumstances

Examples of circumstances that may create a real, significant and imminent risk of moderate to severe harm include, but are not limited to:

- Exposure to toxic vapors resulting from flammable or corrosive chemicals used in the manufacture of illicit drugs;
- The circumstances surrounding the death of one child provides reason to believe that another child is at real, significant and imminent risk of harm;
- Exposing a child to an environment that significantly affects the health and safety of the child, based on the sale or manufacture of illegal drugs;
- A court has adjudicated a parent as unfit and the parent has not completed services that would correct the conditions or behavior leading to the court finding;
- Being coerced or forced to participate in or witness the use of physical force or restraint of another person.

Environment Injurious

Environment injurious includes incidents where the circumstances **may** create a real, significant, and imminent risk of moderate to severe harm.

Examples of circumstances of an environment injurious include, but are not limited to:

- Domestic violence: An incident of past or current domestic violence when the domestic violence creates a real, significant, and imminent risk of moderate to severe harm to the child's health, physical well-being, or welfare, and the parent or caregiver has failed to exercise reasonable precautionary measures to prevent or mitigate the risk of harm to the child;
- A perpetrator of child abuse who has been court ordered to remain out of the home returns home and has access to the abused child;

- Anyone living in the home who has a documented history of violence directed toward children or has been arrested for violence directed to a child;
- Exposure to toxic vapors resulting from flammable and/or corrosive chemicals used in the manufacture of illicit drugs;
- Surviving siblings of a child who dies as a result of unsafe sleep practices where there are other safety issues that place the surviving siblings at risk;
- Coercing or forcing the child to participate in or the witness the physical abuse or restraint of another person;
- The circumstances surrounding the death of a child provide reason to believe that a sibling or another child is in real, significant and imminent risk of moderate to severe harm;
- Exposing the child to an environment that significantly affects the health and safety of the child, based on the sale or manufacture of illegal drugs;
- A court has adjudicated a parent as unfit and the parent has not completed services that would correct the conditions or behavior leading to the court finding;
- Allowing, encouraging or coercing a child to be involved in a criminal activity;
- Children in the home of a stillborn child whose still birth was the direct result of an action by the parent;
- Children in the home of a stillborn child who was delivered substance exposed;
- Substance Abuse/Dependence: an incident or behavior caused by a parent or caregiver's substance use creates a real, significant, and imminent risk of moderate to severe harm to a child's health, physical well-being or welfare, **and** the parent or caregiver has failed to exercise reasonable precautionary measures to prevent or mitigate the risk of moderate to severe harm to the child;
- Prior Harm to a Child: The prior harm to one child creates a real, significant, and imminent risk of moderate to severe harm to another child's health, physical well-being or welfare **and** the parent or caregiver has failed to exercise reasonable precautionary measures to prevent or mitigate the risk of moderate to severe harm to the other child; or
- Mental Health: An incident or behavior by the parent/caregiver that is symptomatic of mental illness creates a real, significant, and imminent risk of moderate to severe harm to the child's health, physical well-being or welfare, **and** the parent or caregiver has failed to exercise reasonable precautionary measures to prevent or mitigate the likelihood of harm to the child.

Example of a circumstance that in and of itself does not constitute "risk of harm": Failure to follow a service plan does not in and of itself constitute an allegation of environment injurious.

b) Taking a Report

1) The reporter/source must have reason to believe that the incident/circumstance that created an environment injurious or substantial risk of injury resulted from a parent or caregiver placing a child or allowing a child to be in an environment that is injurious and that the likelihood of harm to the child is due to the parent or caregiver's blatant disregard for the health and welfare of the child (NEGLECT).

2) Factors to be considered include:

Whether there is a real and significant danger sufficient to justify taking a report is determined by any of the following factors. All factors need **not** be present to justify taking the report. One factor alone may present sufficient danger to justify taking the report:

A) The child's age;

B) The child's medical condition, behavioral, mental or emotional problems, developmental disability, or physical handicap, particularly as it relates to his or her ability to protect him or herself;

C) The severity of occurrences;

D) The frequency of occurrences;

E) The alleged perpetrator's physical, mental and/or emotional abilities, particularly as it relates to his or her ability to control his or her actions and behavior;

F) The dynamics of the relationship between the household members and the child (e.g., is the child treated differently than other children in the home?);

G) The previous history of indicated abuse or neglect;

H) The current stresses/crisis in the home;

I) The presence of other supportive persons in the home; or

J) The precautionary measures exercised by a parent or caregiver to protect the child from harm.

Note: If the blatant disregard alleged in the death of a child involves bedsharing or an unsafe sleep environment, **Allegation #60** may be appropriate for surviving siblings or other children residing in the home, but only if those children are infants, are developmentally disabled, have special health care needs or are medically compromised.

Note: The narrative of a report of this allegation must document an environment injurious in order to justify taking the report, as well as any other factors that had a bearing on the decision to take the report.

c) Investigating a Report

1) Required Contacts

All contacts and attempted contacts must be documented in a contact note within 48 hours.

There are no additional contacts specific to this allegation.

2) Required Activities

All investigative activities must be documented in a contact or case note within 48 hours.

A) If a child has special health care needs, as defined in **Procedures 302, Appendix O, Referral for Nursing Consultation Services**, the Child Protection Specialist must complete a DCFS nurse referral.

B) A waiver of any of the above requirements must be approved by the Child Protection Supervisor and may require approval by the Area Administrator. Details of the request and the Supervisor's decision must be documented in a supervisory note.

3) Required Documentation

A) Documentation and evidence that a child was placed in an environment injurious and any relevant medical records.

B) A waiver of any of the above requirements must be approved by the Child Protection Supervisor and may require approval by the Area Administrator. Details of the request and the Supervisor's decision must be documented in a supervisory note.

4) Assessment of Factors and Evidence to Determine a Final Finding

Factors to be considered include:

A) Child, Caregiver, and Incident Factors

- What is the child's age?
- Does the victim have a medical condition, behavioral, mental/emotional problem or disability that impacts his/her ability to protect himself or herself or that significantly increases the caregiver's stress level?

- Is there a pattern of similar instances with this child or other children for whom the parent or caregiver is responsible?
- What is the severity of the incident of substantial risk or environment injurious?
- What is the location or nature of potential harm?
- Was an object/instrument used on the victim?
- Is there a previous history of abuse or neglect or do persons interviewed report previous injuries to the child?
- What dynamics are present between the victim and the parent? Identify the child's level of fear of the caregiver. Does the caregiver appear to be concerned about the child's welfare and protection? Is there an appropriate parent/caregiver/child relationship?

B) Domestic Violence

- Is there is a history of past incidents of domestic violence as confirmed through interviews with family with members, collateral contacts, police and LEADS reports?
- What is the nature of the domestic violence (e.g., yelling and screaming vs. physical contact or injury)?
- Have weapons been used or brandished?
- What is the involvement of the children during domestic violence incidents (e.g., present in the immediate vicinity, attempted to intervene, or out of immediate area?)
- Does the victim of domestic violence have the ability or wherewithal to use a support system?

C) Information Concerning Mental Health Issues

- What is the nature of the clinical diagnosis, if there is one?
- Is the nature of the illness such that medication controls inappropriate or harmful behaviors? If so, what is the level of medication compliance?
- Do the caregiver's hallucinations or delusions negatively affect the child and/or the caregiver's ability to provide child care?

- Is there is a history of psychiatric hospitalizations?
- What is the history of the caregiver's treatment and treatment compliance history?

D) Substance Abuse Issues

Identify substance use issues involving the parents or household members, and if they have involvement in the manufacture and distribution of illegal drugs.

Allegation of Harm #11/61
CUTS, BRUISES, WELTS, ABRASIONS & ORAL INJURIES

a) Definition

Cut (Laceration)

A cut is an opening, incision or break in the skin made by some external agent.

Bruise

A bruise is an injury which results in bleeding under the skin, and in which skin is discolored but not broken. A bruise can also be called ecchymosis, contusions, or petechiae.

Welt

A welt is an elevation on the skin produced by a lash, blow, or allergic stimulus. The skin is not broken and the mark is reversible.

Abrasion

An abrasion is a scraping away of the skin.

Oral Injuries

Oral injuries are injuries to the child's mouth, such as broken teeth or frenulum tears.

b) Taking a Report

The reporter/source has reason to believe that the cuts, bruises, welts, abrasions, or oral injuries resulted from one of the following:

1) A direct action of the parent, caregiver, immediate family member, other person residing in the home, the parent's paramour, or other person responsible for the child's welfare (ABUSE);

2) The failure of the parent, caregiver, immediate family member, other person residing in the home, the parent's paramour, or other person responsible for the child's welfare to make reasonable efforts to stop an action by another person which resulted in cuts, bruises, welts, and abrasions (ABUSE); or

3) Blatant disregard of parental/caregiver responsibilities that resulted in the child sustaining cuts, bruises, welts, and abrasions (NEGLECT).

4) Factors to be considered include:

Not every cut, bruise, welt, abrasion or oral injury constitutes an allegation of abuse or neglect. The following factors should be considered when determining whether an injury that resulted in cuts, bruises, welts, abrasions or oral injuries constitutes an allegation of abuse or neglect:

- The child's age, mobility and developmental stage; bruises on children younger than 6 months are highly suspicious;
- The child's medical condition, behavioral, mental, or emotional problems, developmental disability, or physical handicap, particularly as they relate to the child's potential for victimization;
- A pattern or chronicity of similar instances; however, a single incident can constitute an allegation of abuse or neglect;
- The severity/extent of the cuts, bruises, welts, abrasions or oral injuries (size, number, depth, extent of discoloration); some bruises may fade quickly, such as around a young child's mouth, but still be considered serious;
- The location of the cuts, bruises, welts, abrasions or oral injuries; accidental bruises are frequently seen over boney areas such as knees, shins, the forehead, and other exposed bony surfaces. Facial bruises or bruises located on padded areas such as the torso, buttocks, cheeks, genitalia, or on relatively protected areas like the ear lobes, neck or upper lip, or on soft areas such as the stomach are highly suspicious;
- The pattern of the injury;
- Was an object/instrument was used on the child;
- Previous history of indicated abuse or neglect; and
- History of previous injuries.

c) Investigating a Report

1) Required Contacts

All contacts and attempted contacts must be documented in a contact note within 48 hours.

A) Law enforcement shall be notified verbally and in writing (**CANTS 14**) regarding all infants under 12 months with any type of bruising, for all children 24 months and younger with multiple bruises, or when there is an SOR on a child 3 years and younger with a previous finding of abuse.

B) A waiver of any of the above requirements must be approved by the Child Protection Supervisor and may require approval by the Area Administrator. Details of the request and the Supervisor's decision must be documented in a supervisory note.

2) Required Activities

All investigative activities must be documented in a contact or case note within 48 hours.

A) A medical examination of the child is required for this allegation and shall not be waived if the child is an infant, is non-verbal, or is developmentally delayed. In a hospital setting, the Child Protection Specialist should request that the treating physician or nurse complete a diagram supplied by the hospital or use the **CANTS 2A/B**.

B) A waiver of any of the above requirements must be approved by the Child Protection Supervisor and may require approval by the Area Administrator. Details of the request and the Supervisor's decision must be documented in a supervisory note.

3) Required Documentation

A) Documented medical diagnosis that the child sustained cuts, bruises, welts, abrasions or an oral injury and all relevant medical records.

B) To make a finding of abuse (**Allegation #11**), documentation of a medical opinion has been obtained that verifies that the child sustained cuts, bruises, welts, abrasions or oral injuries as a result of a direct action of the perpetrator, or the perpetrator has admitted to harming the child. The Child Protection Supervisor must review the medical documentation to ensure report findings do not conflict with medical opinion.

C) To make a finding of neglect (**Allegation #61**), a medical opinion has been obtained that verifies the child sustained cuts, bruises, sustained welts, abrasions or oral injuries as a the result of blatant disregard by an eligible perpetrator.

D) A waiver of any of the above requirements must be approved by the Child Protection Supervisor and may require approval by the Area Administrator. Details of the request and the Supervisor's decision must be documented in a supervisory note.

4) Assessment Factors and Evidence to Determine a Final Finding

Factors to be considered include:

- What is the child's age, mobility and developmental stage? Is the child able to sit up, crawl or walk?

  The less mobile the child is, the less likely the child is to receive accidental bruising.

- Does the child have a medical condition; behavioral, mental or emotional problems; any disability or handicap that impacts the child's ability to protect him or herself or that significantly increases a caregiver's stress level?

- Is there a pattern of similar instances with the child or other children for whom the parent/caregiver has been responsible?

  Note: One incident is sufficient to indicate a report of abuse or neglect.

- What is the severity and location (i.e., size, number, depth of cut and extent of discoloration of the bruising) of the injury to the child's head, face or body?

- Accidental bruising usually occurs over bony prominences such as the knees, shins, forehead or elbows. Injuries to the cheeks, ears, genital, thighs and buttocks are more likely to be indicative of abusive treatment. Bruises surrounding a child's mouth may be associated with attempts to force feed or to make a child stop crying. Falls usually produce bruising on a single plane of the body, while inflicted injuries generally occur over multiple planes.

- Was an object/instrument used on the child? The use of an instrument does not in and of itself constitute an indicated finding, but multiple injuries resulting from the use of an instrument is significant.

- Bruises with sharply defined borders are almost always inflicted. An electric cord produces a loop mark, belts produce strap marks and both generally wrap around multiple planes of the body. Boards and paddles may leave linear injuries while other instruments may leave distinctive, patterned injures.

- Is there a previous history of abuse and/or neglect, or do persons interviewed report previous injuries to the child?

- More weight should be given to a documented history, and DCFS files used as a basis for identifying history should be reviewed prior to being considered a factor. History described by subjects or collaterals (e.g., child injuries, incidents of domestic violence) that is undocumented should be evaluated and factored into the overall assessment of safety.

- What dynamics are present between the child and the parent?

- Identify the child's level of fear of the caregiver. Does the caregiver appear to be concerned about child's welfare and protection? Is there an appropriate parent-child relationship? An apparent lack of fear of the parent/caregiver is only one factor to be considered and does not mean the child is not being abused or neglected.

- Was the injury inflicted through corporal punishment? Corporal punishment suggests non-accidental or intentional injury. An assessment of the intentional injury must be made to determine if the corporal punishment was **excessive**.

- Is the explanation of the injury consistent with the injury? Consistency may be determined either through an analysis of the injury by a medical professional, or through consistent explanations of the incident obtained from witnesses of the incident across settings (i.e., 0-3 service providers, day care providers, teachers, other school personnel).

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Allegation of Harm #12/62
HUMAN BITES

a) Definition

Human Bite

A human bite is a bruise, cut or indentation in the skin caused by seizing, piercing, or cutting the skin with human teeth.

b) Taking a Report

The reporter/source has reason to believe that the human bite resulted from one of the following:

1) A direct action of the parent, caregiver, immediate family member, other person residing in the home, the parent's paramour, or other person responsible for the child's welfare (ABUSE);

2) The failure of the parent, caregiver, immediate family member, other person residing in the home, the parent's paramour, or other person responsible for the child's welfare to make reasonable efforts to stop an action by another person which resulted in a human bite (ABUSE); or

3) Blatant disregard of parental/caregiver responsibilities that resulted in the child sustaining a human bite (NEGLECT).

c) Investigating a Report

1) Required Contacts

All contacts and attempted contacts must be documented in a contact note within 48 hours.

There are no additional contacts specific to this allegation.

2) Required Activities

All investigative activities must be documented in a contact or case note within 48 hours.

In areas served by a Child Advocacy Center, investigations must be coordinated with the center if the center is willing to work with this allegation.

A) A medical examination of the child is required for this allegation and shall not be waived if the child is an infant, is non-verbal, or is developmentally delayed. In a hospital setting, the Child Protection Specialist should request that the treating physician or nurse complete a diagram supplied by the hospital or use the **CANTS 2A/B**.

B) A waiver of any of the above requirements must be approved by the Child Protection Supervisor and may require approval by the Area Administrator. Details of the request and the Supervisor's decision must be documented in a supervisory note.

3) Required Documentation

A) Documented medical diagnosis that the child sustained a human bite and all relevant medical records.

B) A waiver of any of the above requirements must be approved by the Area Administrator. Details of the request and the Administrator's decision must be documented in a supervisory note.

4) Assessment of Factors and Evidence to Determine a Final Finding

There are no additional factors specific to this allegation.

Allegation of Harm #13/63
SPRAINS/DISLOCATIONS

a) Definition

Sprain

A sprain is trauma to a joint that causes pain and disability depending upon the degree of injury to ligaments and/or surrounding muscle tissue. In a severe sprain, ligaments and/or muscle tissue may be completely torn.

The symptoms of a sprain are pain, rapid localized swelling of the affected area, heat, joint laxity and a reduced range of motion with limitation of function.

Dislocation

A dislocation is the displacement of any part, specifically the temporary displacement of a bone from its normal position in a joint.

Types of dislocations include:

- **Complicated**

  A complicated dislocation is associated with other major injuries.

- **Compound**

  A compound dislocation is one in which the joint is exposed to the external air.

- **Closed**

  A closed dislocation is a simple dislocation.

- **Complete**

  A complete dislocation is a dislocation which completely separates the surfaces of a joint.

b) Taking a Report

The reporter/source has reason to believe that the sprain or dislocation resulted from one of the following:

1) A direct action of the parent, caregiver, immediate family member, other person residing in the home, the parent's paramour, or other person responsible for the child's welfare (ABUSE);

2) The failure of the parent, caregiver, immediate family member, other person residing in the home, the parent's paramour, or other person responsible for the child's welfare to make reasonable efforts to stop an action by another person which resulted in the child sustaining a sprain or dislocation (ABUSE); or

3) Blatant disregard of parental/caregiver responsibilities that resulted in the child sustaining a sprain or dislocation (NEGLECT).

c) Investigating a Report

1) Required Contacts

All contacts and attempted contacts must be documented in a contact note within 48 hours.

There are no additional contacts specific to this allegation.

2) Required Activities

All investigative activities must be documented in a contact or case note within 48 hours.

A) A medical examination of the child is required for this allegation and shall not be waived if the child is an infant, is non-verbal, or is developmentally delayed. In a hospital setting, the Child Protection Specialist should request that the treating physician or nurse complete a diagram supplied by the hospital or use the **CANTS 2A/B**.

B) A waiver of any of the above requirements must be approved by the Child Protection Supervisor and may require approval by the Area Administrator. Details of the request and the Supervisor's decision must be documented in a supervisory note.

3) Required Documentation

A) Documented medical diagnosis that the child sustained a sprain or dislocation and all relevant medical records.

B) To make a finding of abuse (**Allegation #13**), documentation has been obtained that verifies that the child sustained a sprain or dislocation as a result of a direct action of the perpetrator or the alleged perpetrator has admitted to harming the child. The Child Protection Specialist and Supervisor must review the medical documentation to ensure report findings do not conflict with medical opinion.

C) To make a finding of neglect (**Allegation #63**), documentation has been obtained that verifies the child sustained a sprain or dislocation as a result of blatant disregard by an eligible perpetrator.

D) A waiver of any of the above requirements must be approved by the Child Protection Supervisor and may require approval by the Area Administrator. Details of the request and the Supervisor's decision must be documented in a supervisory note.

4) Assessment of Factors and Evidence to Determine a Final Finding

There are no additional factors specific to this allegation.

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Allegation of Harm #14/64
TYING/CLOSE CONFINEMENT

a) Definition

Tying

Tying means unreasonable restriction of a child's mobility, actions or physical functioning by tying the child to a fixed (or heavy) object, or tying limbs together.

Confinement

Confinement means forcing the child to remain in a closely confined area that restricts physical movement.

Examples of tying and close confinement include, but are not limited to:

- Locking a child in a closet or small room;
- Tying one or more limbs to a bed, chair, or other object except as authorized by a licensed physician;
- Tying a child's hands behind his or her back;
- Putting child in a cage; or
- Preventing the child's ability to escape in case of an emergency due to a locked or blocked exit.

Note: A parent or other person responsible for a child's care, who forces a child to remain in a cage of any size while denying the child use of bathroom facilities and/or food and/or water, commits an act of neglect, cruelty and depravity which should be referred to law enforcement for investigation.

b) Taking a Report

The reporter/source has reason to believe the child was tied or closely confined as the result of one of the following:

1) A direct action of the parent, caregiver, immediate family member, other person residing in the home, the parent's paramour, or other person(s) responsible for the child's welfare (ABUSE);

2) The failure of the parent, caregiver, immediate family member, other person residing in the home, the parent's paramour, or other person responsible for the child's welfare to make reasonable efforts to stop an action by another person which resulted in a tying or close confinement (ABUSE).

c) **Investigating a Report**

1) Required Contacts

All contacts and attempted contacts must be documented in a contact note within 48 hours.

There are no additional contacts specific to this allegation.

2) Required Activities

All investigative activities must be documented in a contact or case note within 48 hours.

A) For confinement cases, photographs of and a detailed description of the confining space and the circumstances surrounding the confinement must be included in the investigation file including:

i) Size of the space;

ii) Access to help/assistance;

iii) Heat/ventilation present;

iv) Duration and frequency of confinement;

v) Presence or absence of lighting; and

vi) Reason for confinement.

B) Determine that the victim was subjected to an unreasonable restriction of mobility or physical movement. Where there are marks/bruises due to close confinement, **Allegation #11 Cuts, Bruises, Welts, Abrasions and Oral Injuries,** should be added to the report.

C) For tying cases, the following information must be photographed and documented. Photographs must be placed in the investigative file.

i) Type of material used for tying;

ii) Description of the object the child was tied to;

iii) Access to help/assistance;

iv) Duration and frequency of tying;

v) Reason for tying; and

vi) Presence of bruising or other marks on the child from being tied.

D) Determine the type and possible plausible cause of any physical harm, including the exact location of the injury, type, extent of injury, age, and pattern if multiple injuries are present due to being tied. Where there are marks/bruises due to tying, **Allegation #11 Cuts, Bruises, Welts, Abrasions and Oral Injuries**, should be added to the report.

E) A waiver of any of the above requirements must be approved by the Child Protection Supervisor and may require approval by the Area Administrator. Details of the request and the Supervisor's decision must be documented in a supervisory note.

3) Documentation

A) A statement has been obtained from the victim, if the child is verbal, alleging tying/close confinement. Documentation of the victim's statement should include copies of the notes taken during the Forensic Interview (FI) or an interview summary provided by the Child Advocacy Center, if CAC involved.

B) When the alleged perpetrator contends that the tying or confinement was recommended by a physician or psychiatrist as a means of controlling the child's behavior, verification must be obtained from the recommending physician or psychiatrist. The Child Protection Specialist shall interview the physician or psychiatrist to determine what his or her instructions were and what type of condition the tying or confinement was meant to control. The Child Protection Specialist shall consult with the Child Protection Supervisor regarding any such instructions and seek further advice from the Department's Clinical staff and/or medical consultant, if necessary.

C) Any and all relevant medical records.

D) Secure evidence that the tying/close confinement is a direct result of some action by an eligible perpetrator or the failure of a caregiver to stop the action of another person that results in tying/close confinement.

E) A waiver of any of the above requirements must be approved by the Child Protection Supervisor and may require approval by the Area Administrator. Details of the request and the Supervisor's decision must be documented in a supervisory note.

4) Assessment of Factors and Evidence to Determine a Final Finding

There are no additional factors specific to this allegation.

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Allegation of Harm #15/65
SUBSTANCE MISUSE

a) Definitions

"Controlled substances"

Controlled substances means those substances defined in subsection (f) of the Illinois Controlled Substances Act [720 ILCS 570/102] and includes, but is not limited to, such drugs as heroin, cocaine, morphine, peyote, LSD, PCP, pentazocine, and methaqualone.

Marijuana, hashish, and other derivatives of the plant *cannabis sativa* **are not** controlled substances.

"Substance affected infants"

Substance affected infant means an infant who is born with one or more controlled substances in his/her system or who has been diagnosed with fetal alcohol syndrome.

Option A

Included in this option is the consumption by the victim of a mood altering chemical, capable of intoxication, to the extent that it affects the child's health, behavior, motor coordination, judgment or intellectual capacity. Mood altering chemicals include cannabis (marijuana), hallucinogens, stimulants (including cocaine and methamphetamine), sedatives (including alcohol and Valium), narcotics or inhalants. (ABUSE/NEGLECT). Abuse occurs if the parent provides the substance to the child. Neglect occurs if the parent allows the use or fails to protect the child from consumption.

Option B

A diagnosis of Fetal Alcohol Syndrome or drug or alcohol withdrawal, including withdrawal from cannabis or its derivatives, at birth caused by the mother's use of drugs or alcohol is included in this definition and is considered child neglect (NEGLECT).

Note: Methadone withdrawal or other withdrawal verified as under the auspices of a drug treatment program in not included under drug withdrawal at birth.

Option C

This option includes any amount of a controlled substance or a metabolite thereof that is found in the blood, umbilical cord, urine or meconium (newborn's first stool) of a newborn infant. (NEGLECT)

The presence of such substances shall not be considered as child neglect if the presence is due to medical treatment of the mother or infant.

Note: Methadone withdrawal or other withdrawal verified as under the auspices of a drug treatment program is not included under drug withdrawal at birth.

(Options B and C when diagnosed by a physician constitute prima facie evidence of neglect.)

Examples

- Giving a minor (unless prescribed by a physician) any amount of heroin, cocaine, morphine, peyote, LSD, PCP, pentazocine, or methaqualone or encouraging, insisting, or permitting a minor's consumption of the above substances.
- Giving any mood altering substance, including alcohol or sedatives, unless prescribed by a physician, to an infant or toddler.
- Encouraging, insisting, or permitting any minor to become intoxicated by alcohol, drugs, or another mood altering substance even if on an infrequent basis.

Parents supervising children permitted to drink a small amount of alcohol as a part of a religious or family celebration should not be considered abusive/neglectful.

b) Taking a Report

The reporter/source has reason to believe that the substance misuse resulted from one of the following:

1) A direct action of the parent, caregiver, immediate family member, other person residing in the home, the parent's paramour, or other person responsible for the child's welfare. (ABUSE);

2) The failure of the parent, caregiver, immediate family member, other person residing in the home, the parent's paramour, or other person responsible for the child's welfare to stop another person from giving mood altering substances to the child. (ABUSE);

3) Blatant disregard of parental (or other person responsible for the child's welfare) responsibilities which resulted in the child's substance misuse. This includes the failure of the parent or caregiver to take reasonable actions to prevent the child from misusing mood altering substances (NEGLECT);

4) Blatant disregard of parental responsibilities which resulted in the child's Fetal Alcohol Syndrome or drug or alcohol withdrawal at birth (NEGLECT); or

5) Blatant disregard of parental responsibilities which resulted in any amount of a controlled substance or a metabolite thereof, found in the blood, umbilical cord, urine or meconium of a newborn infant (NEGLECT).

c) Investigating a Report

1) Required Contacts:

All contacts and attempted contacts must be documented in a contact note within 48 hours.

There are no additional contacts specific to this allegation.

2) Required Activities:

All investigative activities must be documented in a contact or case note within 48 hours.

A) A medical examination of the child is required for this allegation and shall not be waived if the child is an infant, is non-verbal, or is developmentally delayed. In a hospital setting, the Child Protection Specialist should request that the treating physician or nurse complete a diagram supplied by the hospital or use the **CANTS 2A/B**.

B) As the presence of drugs/substances and alcohol may dissipate depending upon their chemical structure, immediate action is required. Child Protection Specialists are to ensure the child receives immediate medical attention (same day). Medical examination of involved children (victims and non-victims) is required when there are suspicions they may have taken or been given inappropriate medication or poisonous or noxious substances, whether legal or illicit. The Child Protection Specialist is to make diligent efforts to immediately communicate to the physician to whom the child is to be taken prior to the examination to alert the doctor of the suspicion so appropriate testing (blood, urine, etc.) can occur.

There must be a follow-up (within one business day after the examination) interview with the medical provider to discuss consistency of explanation provided by the parent/caregiver, outcome of the examination/lab work, discharge instructions, opinion of abuse/neglect, and the child's explanation if verbal. If testing is not complete, request the estimated completion date and meet with the provider following completion.

C) A waiver of any of the above requirements must be approved by the Child Protection Supervisor and may require approval by the Area Administrator. Details of the request and the Supervisor's decision must be documented in a supervisory note.

3) Required Documentation

A) Documented medical diagnosis of substance misuse and all relevant medical records.

B) Evidence that a child has consumed mood-altering chemicals that were provided by or left accessible the child's parent or caregiver, or taken at the encouragement or insistence of an eligible perpetrator.

C) A waiver of any of the above requirements must be approved by the Child Protection Supervisor and may require approval by the Area Administrator. Details of the request and the Supervisor's decision must be documented in a supervisory note.

4) Assessment of Factors and Evidence to Determine a Finding

Factors to be considered include:

- The age of the child;
- The frequency of misuse;
- The amount of substance consumed;
- The degree of behavioral dysfunction or physical impairment linked to substance use;
- The child's culture as it relates to use of alcohol in religious ceremonies, family gatherings/celebrations, or special occasions;
- Whether the parent or caregiver made reasonable attempts to control or seek help for an older child's substance misuse;
- Whether the parent or caregiver knew, or should have known, of the child's substance abuse; and
- The parent or caregiver failed to take reasonable precautionary measures to prevent consumption.

Allegation of Harm #16
TORTURE

a) Definition

Torture

Torture means inflicting or subjecting the child to intense physical and/or mental pain, suffering or agony that can be a onetime incident or ongoing. Torture can be severe, repetitive, or prolonged. This definition also includes genital mutilation.

b) Taking a Report

The reporter/source has reason to believe that the torture resulted from one of the following:

1) A direct action of the parent, caregiver, immediate family member, other person residing in the home, the parent's paramour, or other person responsible for the child's welfare (ABUSE); or

2) The failure of the parent, caregiver, immediate family member, other person residing in the home, the parent's paramour, or other person responsible for the child's welfare to make reasonable efforts to stop another person from torturing the child (ABUSE).

c) Investigating a Report

1) Required Contacts:

All contacts and attempted contacts must be documented in a contact note within 48 hours.

There are no additional contacts specific to this allegation.

2) Required Activities:

All investigative activities must be documented in a contact or case note within 48 hours.

In areas served by a Child Advocacy Center, investigations must be coordinated with the center if the center is willing to work with this allegation.

A) The Child Protection Specialist shall consult with the Child Protection Supervisor to discuss the need to have the child victim medically examined. A medical exam is required for this allegation and shall not be waived if the child is an infant, is non-verbal, or is developmentally delayed. If the alleged torture is believed to have been particularly violent, a recommendation should be made to the treating physician to perform a long bone scan.

B) A waiver of any of the above requirements must be approved by the Child Protection Supervisor and may require approval by the Area Administrator. Details of the request and the Supervisor's decision must be documented in a supervisory note.

3) Required Documentation

A) A statement has been obtained from the victim, if the child is verbal, alleging harm that is considered torture. Documentation of the victim's statement should include copies of the notes taken during the FI or an interview summary provided by the Child Advocacy Center, if CAC involved.

B) Verifiable documented evidence that the victim exhibits signs of physical and/or mental pain, suffering, or agony that are the result of actions by an alleged perpetrator that may be a one-time incident or repetitive, increased, or prolonged. Include a clear and concise description of the alleged perpetrator's actions.

C) To make a finding of abuse (**Allegation #16**), documentation has been obtained that verifies that the child was tortured as a result of a direct action of the perpetrator, or the perpetrator has admitted to torturing the child. The Child Protection Specialist and Supervisor must review the medical documentation to ensure report findings do not conflict with the medical opinion.

D) A waiver of any of the above requirements must be approved by the Child Protection Supervisor and may require approval by the Area Administrator. Details of the request and the Supervisor's decision must be documented in a supervisory note.

4) Assessment of Factors and Evidence to Determine a Finding

There are no additional factors specific to this allegation.

Allegation of Harm #17/67
MENTAL AND EMOTIONAL IMPAIRMENT

a) Definition

Mental and Emotional Impairment

Mental and emotional impairment means injury to the intellectual, emotional or psychological development of a child as evidenced by observable and substantial impairment in the child's ability to function within a normal range of performance and behavior.

b) Taking a Report

The reporter/source has reason to believe that the mental injury resulted from the following:

A) A direct action of the parent, caregiver, immediate family member, other person residing in the home, the parent's paramour, or other person responsible for the child's welfare (ABUSE); or

B) The blatant disregard of parental or other person responsible for the child's welfare responsibilities in providing the proper or necessary support or other care necessary for the child's well-being (NEGLECT).

c) Investigating a Report

1) Required Contacts:

All contacts and attempted contacts must be documented in a contact note within 48 hours.

There are no additional contacts specific to this allegation.

2) Required Activities:

All investigative activities must be documented in a contact or case note within 48 hours.

There are no additional activities specific to this allegation.

3) Required Documentation

A) Secure verification from a qualified expert, as defined below, that a child has suffered observable and substantial impairment to their ability to function within a normal range of performance or behavior due to injury to the intellectual, emotional, or psychological development.

Verification **must** come from a professional source that has assessed the child and can verify a causal link between the child's mental injury and the action or behavior of the alleged perpetrator, or the blatant disregard exhibited by the parent or caregiver.

B) Identify and document the causal link between the child's mental injury and the action, behavior or blatant disregard exhibited by the parent/caregiver/alleged perpetrator (e.g. the child's impairment must be directly related to the parent's action).

C) A waiver of any of the above requirements must be approved by the Child Protection Supervisor and may require approval by the Area Administrator. Details of the request and the Supervisor's decision must be documented in a supervisory note.

4) Assessment of Factors and Evidence to Determine a Finding

There are no additional factors specific to this allegation.

Allegation of Harm #18
SEXUALLY TRANSMITTED DISEASES

a) Definition

Sexually Transmitted Diseases

Sexually transmitted diseases are diseases that are acquired originally as a result of sexual penetration or sexual conduct with an individual who is afflicted with the disease.

The diseases may include, but are not limited to:

- Acquired Immune Deficiency Syndrome (AIDS)
- AIDS Related Complex (ARC)
- Chancroid
- Chlamydia Trachomatis
- Genital Herpes
- Genital Warts
- Gonorrhea
- Granuloma Inquinale
- HIV Infection
- Lymphorganuloma Venereum
- Neisseria Gonorrhea
- Proctitis
- Syphilis
- Trichomonas Vaginalis (Symptomatic)

Sexual penetration is defined in the Illinois Criminal Sexual Assault Act as "*any contact, however slight, between the sex organ or anus of one person by an object, the sex organ, mouth or anus of another person, or any intrusion, however slight, of any part of the body of one person or any animal or object into the sex organ or anus of another person, including but not limited to cunnilingus, fellatio or anal penetration.*"

Sexual conduct is defined in the Illinois Criminal Sexual Assault Act as "*any intentional or knowing touching or fondling of the victim or the perpetrator, either directly or through clothing of the sex organs, anus or breast of the victim or the accused, or any part of the body of a child...for the purpose of sexual gratification or arousal of the victim or the accused.*"

b) Taking a Report

The reporter/source has reason to believe that the disease was contracted as the result of one of the following:

1) A direct action of the parent, caregiver, immediate family member, other person residing in the home, the parent's paramour, or other person responsible for the child's welfare (ABUSE);

2) The failure of the parent, caregiver, immediate family member, other person residing in the home, the parent's paramour, or other person responsible for the child's welfare to make reasonable efforts to stop an action by another person which resulted in the child contracting the disease (ABUSE); or

3) The alleged perpetrator is unknown and the available information does not rule out one of the above persons (ABUSE).

c) Investigating a Report

1) Required Contacts:

All contacts and attempted contacts must be documented in a contact note within 48 hours.
There are no additional contacts specific to this allegation.

2) Required Activities:

All investigative activities must be documented in a contact or case note within 48 hours.

In areas served by a Child Advocacy Center, investigations must be coordinated with the center if the center is willing to work with this allegation.

A) **A medical examination of the child is required for this allegation** and shall not be waived. An alleged victim should be tested **within 24 hours of the report**. In a hospital setting, the Child Protection Specialist should request that the examining/treating physician or nurse complete a diagram supplied by the hospital or use the **CANTS 2A/B**.

B) A waiver of any of the above requirements must be approved by the Child Protection Supervisor and may require approval by the Area Administrator. Details of the request and the Supervisor's decision must be documented in a supervisory note.

3) Documentation Required:

A) Documented medical diagnosis that the child has a Sexually Transmitted Disease and all relevant medical records. Identify and document the type of the disease and all possible methods of transmission. Document the subject's explanation as to how the child might have contracted the disease. Document the physician's statement regarding the consistency of the subject's explanation and the most likely method of transmission.

B) To make a finding of abuse (**Allegation #18**), documentation has been obtained that verifies that the child was given a Sexually Transmitted Disease as a result of a direct action of the perpetrator, or the perpetrator has admitted to transmitting the disease to the child. The Child Protection Specialist and Child Protection Supervisor must review the medical documentation to ensure report findings do not conflict with medical opinion.

C) A waiver of any of the above requirements must be approved by the Child Protection Supervisor and may require approval by the Area Administrator. Details of the request and the Supervisor's decision must be documented in a supervisory note.

4) Assessment of Factors and Evidence to Determine a Finding

There are no additional factors specific to this allegation.

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Allegation of Harm #19
SEXUAL PENETRATION

a) Definition

Sexual Penetration

Sexual penetration is defined in the Illinois Criminal Sexual Assault Act as "*any contact, however slight, between the sex organ or anus of one person by an object, the sex organ, mouth or anus of another person, or any intrusion, however slight, of any part of the body of one person or any animal or object into the sex organ or anus of another person, including but not limited to cunnilingus, fellatio or anal penetration.*"

b) Taking a Report

The reporter/source has reason to believe that the sexual penetration resulted from one of the following:

1) The direct action of a parent, caregiver, immediate family member, other persons residing in the home, the parent's paramour, or other person responsible for the child's welfare (ABUSE);

2) The failure of the parent, caregiver, immediate family member, other person residing in the home, the parent's paramour, or other person responsible for the child's welfare to make reasonable efforts to stop an action by another person which resulted in sexual penetration (ABUSE); or

3) The alleged perpetrator is unknown and the available information does not rule out one of the above persons (ABUSE).

c) Investigating a Report

1) Required Contacts

All contacts and attempted contacts must be documented in a contact note within 48 hours.

A) Interview the alleged child victim(s) in person and individually. Complete a safety assessment (**CERAP**). Non-verbal children must be thoroughly observed and assessed. Observations and assessment must be documented in a contact note.

Note: The Child Protection Specialist must NOT photograph or physically examine a sex abuse victim.

The Child Protection Specialist should not interview the victim if, per local protocol, the case is eligible for a Forensic Interview (FI) or the victim is a child with developmental disabilities who presents with conditions indicative of vulnerability to sexual abuse. The Child Protection Specialist shall refer the involved child to the local CAC for an FI as soon as possible if one has not already been conducted. If the victim is "unsafe," per the **CERAP**, every attempt must be made to arrange an emergency FI.

B) A waiver of any of the above requirements must be approved by the Child Protection Supervisor and may require approval by the Area Administrator. Details of the request and the Supervisor's decision must be documented in a supervisory note.

2) Required Activities

All investigative activities must be documented in a contact or case note within 48 hours.

In areas served by a Child Advocacy Center, investigations must be coordinated with the center if the center is willing to work with this allegation

A) Sex abuse victims may receive a medical examination as a part of the CAC investigation process. A medical examination of the child is required for this allegation; however, the Child Protection Specialist must ensure the victim does not receive multiple medical examinations related to the alleged sexual abuse. A medical examination shall not be waived if the child is an infant, is non-verbal, or is developmentally delayed. In a hospital setting, the Child Protection Specialist should request that the treating physician or nurse complete a diagram supplied either by the hospital or **CANTS 2A/B**.

B) A waiver of any of the above requirements must be approved by the Child Protection Supervisor and may require approval by the Area Administrator. Details of the request and the Supervisor's decision must be documented in a supervisory note.

3) Required Documentation

A) Documented medical evidence/diagnosis that the child was sexually penetrated, medical documentation that does not rule out sexual penetration, and all relevant medical records.

B) To make a finding of abuse (**Allegation #19**), documentation has been obtained that verifies that the child was sexually penetrated as a result of a direct action of the perpetrator, or the perpetrator has admitted to sexually penetrating the child. The Child Protection Specialist and Child Protection Supervisor must review all documentation to ensure report findings do not conflict.

C) A waiver of any of the above requirements must be approved by the Child Protection Supervisor and may require approval by the Area Administrator. Details of the request and the Supervisor's decision must be documented in a supervisory note.

4) Assessment of Factors and Evidence to Determine a Final Finding

There are no additional factors specific to this allegation.

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Allegation of Harm #20
SEXUAL EXPLOITATION

a) Definition

Sexual Exploitation

Sexual exploitation is the use of a child for sexual arousal, gratification, advantage, or profit. Arousal and gratification of sexual need may be inferred from the act itself and surrounding circumstances. The absence of evidence of arousal or gratification should in no way preclude or inhibit an investigation.

Sexual exploitation may occur in person or by virtual presence and includes, but is not limited to:

- Indecent solicitation of a child;
- Explicit verbal or physical enticement, coercion or persuasion;
- Child pornography;
- Exposing a child to sexually explicit material in any form;
- Exposing sexual organs to a child;
- Forcing the child to watch sexual acts;
- Masturbation with or in the child's presence; and
- Other behavior by an eligible perpetrator that, when considered in the context of the circumstances, would lead a reasonable person to conclude that sexual exploitation of a child has occurred.

b) Taking a Report

The reporter/source has reason to believe that the sexual exploitation resulted from one of the following:

1) A direct action of the parent, caregiver, immediate family member, other person residing in the home, the parent's paramour, or other person responsible for the child's welfare (ABUSE); or

2) The failure of the parent, caregiver, immediate family member, another person residing in the home, parent's paramour, or another person responsible for the child's welfare to make reasonable efforts to stop another person from sexually exploiting the child (ABUSE).

c) Investigating a Report

1) Required Contacts

All contacts and attempted contacts must be documented in a contact note within 48 hours.

A) Interview the alleged child victim(s) in person and individually. Complete a safety assessment (**CERAP**). Non-verbal children must be thoroughly observed and assessed. Observations and assessment must be documented in a contact note.

Note: The Child Protection Specialist must NOT photograph or physically examine a sex abuse victim.

The Child Protection Specialist should not interview the victim if, per local protocol, the case is eligible for a Forensic Interview (FI) or the victim is a child with developmental disabilities who presents with conditions indicative of vulnerability to sexual abuse. The Child Protection Specialist shall refer the involved child to the local CAC for an FI, as soon as possible, if one has not already been conducted. If the victim is "unsafe," per the **CERAP**, every attempt must be made to arrange an emergency FI.

B) A waiver of any of the above requirements must be approved by the Child Protection Supervisor and may require approval by the Area Administrator. Details of the request and the Supervisor's decision must be documented in a supervisory note.

2) Required Activities

All investigative activities must be documented in a contact or case note within 48 hours.

In areas served by a Child Advocacy Center, investigations must be coordinated with the center if the center is willing to work with this allegation

There are no additional activities specific to this allegation.

3) Required Documentation

A) A statement has been obtained from the victim, if the victim is verbal, alleging sexual exploitation. Documentation of the victim's statement should include copies of the notes taken during the FI or an interview summary provided by the Child Advocacy Center.

B) A waiver of any of the above requirements must be approved by the Child Protection Supervisor and may require approval by the Area Administrator. Details of the request and the Supervisor's decision must be documented in a supervisory note.

4) Assessment of Factors and Evidence to Determine a Final Finding

There are no additional factors specific to this allegation.

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Allegation of Harm #21
SEXUAL MOLESTATION

a) Definition

Sexual Conduct

Sexual conduct is defined in the Illinois Criminal Sexual Assault Act as "*any intentional or knowing touching or fondling of the victim or the perpetrator, either directly or through clothing of the sex organs, anus or breast of the victim or the accused, or any part of the body of a child...for the purpose of sexual gratification or arousal of the victim or the accused.*"

Arousal and gratification of sexual need may be inferred from the act itself and surrounding circumstances. The absence of evidence of arousal or gratification should in no way preclude or inhibit an investigation.

Parts of the body as used in the examples below refer to the parts of the body described in the definition of sexual conduct found in the Criminal Code of 2012 [720 ILCS 5/11-0.1].

Examples include, but are not limited to:

- Fondling;
- The alleged perpetrator inappropriately touching or pinching of the child's body generally associated with sexual activity; and
- Encouraging, forcing, or permitting the child to touch parts of the alleged perpetrator's body normally associated with sexual activity.

b) Taking a Report

The reporter/source has reason to believe that the sexual molestation resulted from one of the following:

1) The direct action of the parent, caregiver, immediate family member, other person residing in the home, the parent's paramour, or other person responsible for the child's welfare (ABUSE); or

2) The child's parent, caregiver, immediate family member, other person residing in the home, the parent's paramour, or a person responsible for the child's welfare has failed to take reasonable actions to stop another person from sexually molesting the child (ABUSE).

c) Investigating a Report

1) Required Contacts

All contacts and attempted contacts must be documented in a contact note within 48 hours.

A) Interview the alleged child victim(s) in person and individually. Complete a safety assessment (**CERAP**). Non-verbal children must be thoroughly observed and assessed. Observations and assessment must be documented in a contact note.

Note: The Child Protection Specialist must NOT photograph or physically examine a sex abuse victim.

The Child Protection Specialist should not interview the victim if, per local protocol, the case is eligible for a Forensic Interview (FI) or the victim is a child with developmental disabilities who presents with conditions indicative of vulnerability to sexual abuse. The Child Protection Specialist shall refer the involved child to the local CAC for an FI as soon as possible if one has not already been conducted. If the victim is "unsafe," per the **CERAP**, every attempt must be made to arrange an emergency FI.

B) A waiver of any of the above requirements must be approved by the Child Protection Supervisor and may require approval by the Area Administrator. Details of the request and the Supervisor's decision must be documented in a supervisory note.

2) Required Activities

All investigative activities must be documented in a contact or case note within 48 hours.

In areas served by a Child Advocacy Center, investigations must be coordinated with the center if the center is willing to work with this allegation

A) The Child Protection Specialist and Supervisor shall consult to assess whether the child victim should be medically examined.

B) A waiver of any of the above requirements must be approved by the Child Protection Supervisor and may require approval by the Area Administrator. Details of the request and the Supervisor's decision must be documented in a supervisory note.

3) Required Documentation

A) A statement has been obtained from the victim, if the victim is verbal, alleging sexual molestation. Documentation of the victim's statement should include copies of the notes taken during the FI or an interview summary provided by the Child Advocacy Center.

B) A waiver of any of the above requirements must be approved by the Child Protection Supervisor and may require approval by the Area Administrator. Details of the request and the Supervisor's decision must be documented in a supervisory note.

4) Assessment of Factors and Evidence to Determine a Final Finding

There are no additional factors specific to this allegation.

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Allegation of Harm #22
SUBSTANTIAL RISK OF SEXUAL INJURY

a) Definition

Substantial risk of sexual injury means that the parent, caregiver, immediate family member, person in a position of trust, other person residing in the home, or the parent's paramour has created a **real and significant danger** of sexual abuse as explained in the following options.

Option A

An indicated, registered, or convicted sex offender has access to a child and the extent/quality of supervision during contact is believed to be inadequate for the child's protection.

Option B

There are siblings or other children the perpetrator has regular access to and there is a current or pending allegation of sexual abuse.

Option C

Persistent, highly sexualized behavior or knowledge in a very young child (e.g. under the age of five chronologically or developmentally) that is grossly age inappropriate and there is reasonable cause to believe that the most likely manner in which such behavior was learned is in having been sexually abused.

Option D

A member of the household has engaged in child pornography activities outside and/or inside the residence, including the making and/or distribution of child pornography, and has significant access to children and the extent/quality of the supervision of those children is unknown or suspected to be deficient.

Option E

The inappropriate or suggestive behavior of the alleged offender towards a child that would lead a reasonable person to believe the alleged offender has or is placing the child at a real and significant risk of sexual injury. Examples of such behavior include, but are not limited to: sexting, inappropriate gift giving and other grooming behaviors associated with a pattern of behavior designed to increase opportunities for sexual assault and minimize victim resistance, withdrawal and risk of disclosure.